HOSPITAL Topics

GRAPHIC REPORTING ON TODAY'S HOSPITAL PRACTICES

AHA Convention Report

Delegates Ask Joint Commission For Nursing School Accreditation—
meeting report, pages 17-32;
exhibits news, pages 81-88

TOPICS Visits Rome's Salvator Mundi Hospital

page 45

Laundry Washes, Wraps Gloves and Packs

page 131

BUYER'S GUIDE
Page 74

ger Sherman (see page 5)

The New Magazine for Hospitals

SEPTEMBER | 1958

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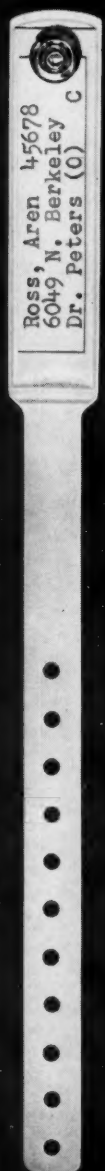

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HOSPITAL Topics
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SEPTEMBER, 1958, VOL. 36, NO. 9

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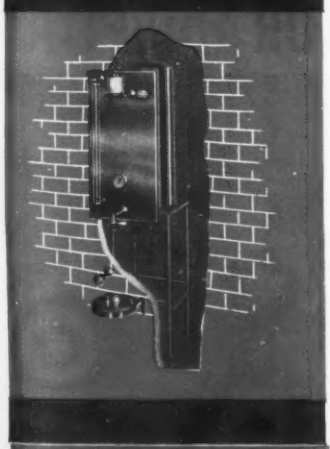

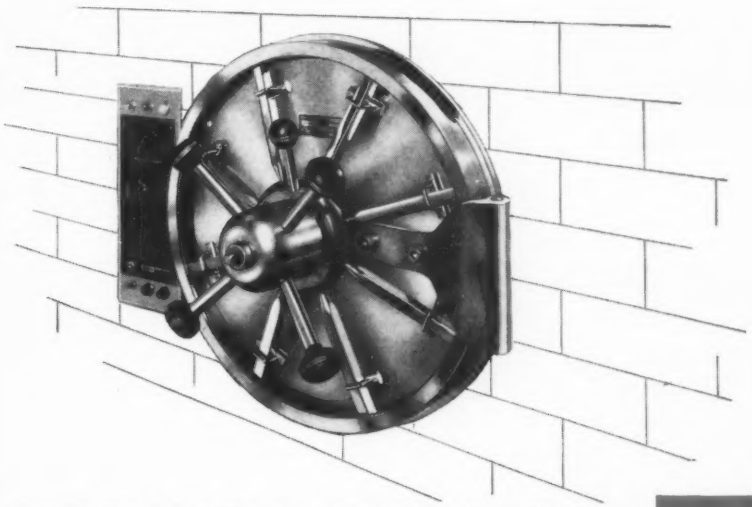

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1. Benson, Margaret E.: **Am. J. Nursing** 57:1134, Sept., 1957.

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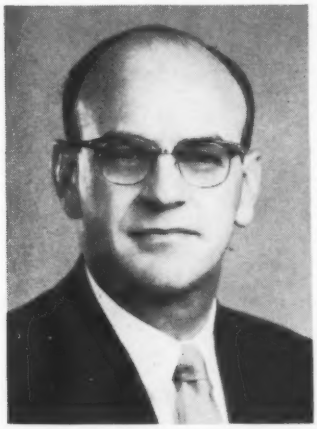
PERSONALITY OF THE MONTH



IN the opinion of Roger Sherman, administrator of Children's Hospital, Akron, Ohio, and president of the Ohio Hospital Association, care of children can be performed better in a single children's unit rather than divided up among adult hospitals.

Any aggressive community of 250,000 or more, he points out, should anticipate the need for such facilities, which not only can provide better care, but also are able to offer better clinical training programs for interns and residents.

In his 14 years at Akron Children's, Mr. Sherman has observed that administration of this type of hospital is complicated by the fluctuations of census, the necessity of more careful conservation of funds, and the always-present scrutiny of parents and relatives. However, he adds, the hospital enjoys a particularly sympathetic spot, and thus, its building fund needs are probably more readily met by the community than those of other institutions.

Mr. Sherman came to Akron from Rochester, Minn., where he had been on the staff of Colonial Hospital, associated with the Mayo Clinic, for nine years. During his last five years at Colonial, he served as assistant administrator.

Born in Alexandria, Minn., Mr. Sherman completed two years of work at Rochester (Minn.) Junior College before entering the hospital field.

Mr. Sherman has been active in hospital organizational work as well as in community service. Before assuming the presidency of the Ohio association, he had served as chairman of a number of committees; he has worked with the American Hospital Association on the volunteer program; and, at present, he is serving on the 12-man advisory committee representing the more than 60 hospitals in Blue Cross of Northeastern Ohio.

After working only three years in Akron, Mr. Sherman's special service in the health field won him the city's Junior Chamber of Commerce award as "Akron's Young Man of the Year."

Mr. Sherman and his wife, Evelyn, are well-experienced in the ways of children. They have five: Roger, Jr., 22; Margaret, 21; Jean and Irene, 17-year-old twins; and William, 15.

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HOSPITAL Topics
The News Magazine for the Hospital Staff

SEPTEMBER, 1958
VOL. 36, NO. 9

Scanning the News

New Phospholipid Found In Malignant Tumors

A team of Japanese biochemists report that they have discovered a new phospholipid — malignolipin — that contains spermine and is found only in malignant tumors.

The scientists, all associated with the department of biochemistry, School of Medicine, Mie Prefectural University, Tsu City, Mie, Japan, predict that the discovery will not only contribute to diagnosis of malignant tumor, but also to the elucidation of tumor pathogenesis and therapy.

Cave Man Amputee Shows Surgery in 43,042 B.C.

Anthropological studies of the "Shanidar Man" reveal that surgery is at least 45,000 years old, according to T. Dale Stewart, curator of physical anthropology, Smithsonian Institution.

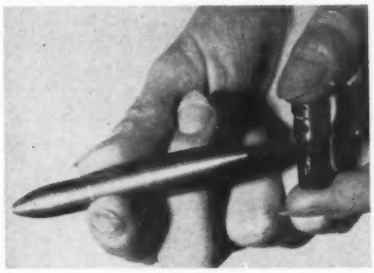
Bone casts of the cave man's skeleton, discovered last year in Iraq, indicate amputation just above the elbow, for a withered arm, possibly done with flint instruments.

3 Dimension Heart Studies Via X-Ray Motion Pictures

Three-dimensional x-ray motion picture studies of the heart can now be made with apparatus just installed at Stanford University School of Medicine, San Francisco.

"We can now study cardiac motion and blood flow through the heart, lungs and great vessels in two planes simultaneously," said Herbert L. Abrams, M.D., Stanford radiologist in charge of the project. "We can also 'stop' the movement down to a thousandth of a second to get sharper views of pumping heart chambers and blood jets."

The new equipment employs two 11-inch "image intensifiers" at right angles to each other. Like ordinary fluoroscopes, the electronic intensifiers form the x-ray picture on their circular screen.



A camera which permits internal surface areas and cavities of the stomach to be photographed in black and white or color, while being viewed, has been created by Norman R. Gosselin, medical research director, Charles Brusch Medical Center, Cambridge, Mass. The gastrocamera, ½ to ¾ inches long and 1/8 inch in diameter, is encased in a 2-inch x 3/8-inch inseparable housing. Under light sedation the patient has no difficulty swallowing the camera, which is attached to a standard gastroscope. Mr. Gosselin began work on his project three years ago as a student at Boston University's College of Industrial Technology where he worked in co-operation with the Physical Research Laboratories.

Blood Clot Dissolving Agent Shows Promise

A new agent, fibrinolysin (plasmin), a derivative of human blood, appears promising in the treatment of blood clots that move from one spot to another, according to a preliminary report in *The Journal of the AMA*.

Results were reported of administration to 52 patients suffering from various types of thromboembolic disease, in which a vessel had been blocked by a clot which had broken loose from its site of formation. Findings, reported by Kenneth M. Moser, M.D., Washington, D.C., included:

—Eighteen patients with deep venous thrombophlebitis of the legs showed "consistently encouraging" results.

—"Some beneficial effect" was noted in four of eight patients with pulmonary embolism.

—In 14 patients with blocking of the cerebral arteries, seven showed some degree of improvement (return of speech and movement), although it was maintained in only four patients.

In spite of the encouraging results, Dr. Moser said there are still areas needing study: certain aspects of the agent's toxicity; establishment of proper dosage schedules; estimation of its value in various thromboembolic stages; the need for anticoagulant treatment after the clot is dissolved.

Male Death Rate Exceeds That of Female, Report Says

Males have a higher death rate than females at all age levels, with the disparity in mortality being smallest at the youngest and oldest ages and at its maximum during adolescence and early adult life, according to a Metropolitan Life Insurance Co. report.

At preschool ages, the death rate for boys is only slightly higher than that for girls, but the ratio increases to a high of nearly two and two-thirds at ages 15 to 24, reflecting largely the number of males involved in fatal accidents.

From ages 25 to 44, accidents continue to account for a large portion of the excess male deaths, but diseases of the heart are almost as important a factor; the heart disease death rates are 62.6 and 19.6 per 100,000 for men and women.

The difference in mortality from

(Continued on page 14)

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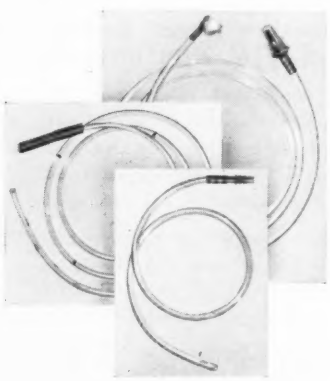

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News Briefs at Press Time

AHA DELEGATES URGE JOINT COMMISSION FOR NURSING SCHOOL ACCREDITATION

Members of AHA House of Delegates, at annual convention in Chicago, voted to ask the National League for Nursing and the American Medical Association to join the AHA in establishing "as rapidly as feasible" an independent joint commission on accreditation of hospital schools of nursing, to replace present accreditation program conducted by NLN.

Other important action of delegates included approval of statement of AHA policy on meeting the hospital needs of the retired aged.

For details on these stories and other convention highlights, see report beginning on page 17.

NO NEW LEGISLATION FOR LOANS TO HOSPITALS

No new legislation for loans to hospitals came out of session of Congress which just ended.

Omnibus housing bill, which included authorization for $50 million additional funds for loans to hospital schools of nursing, was defeated in the House. This means there will be no additional funds this fiscal year for loans to hospital schools, although funds previously authorized are still available.

Legislation for loans to municipalities (Fulbright bill) was bottled up in House rules committee. Defeat of this bill has been predicted by TOPICS since bill was introduced in opening days of this session.

Legislation to provide $279.5 million in loans to depressed areas passed both houses, but TOPICS' Washington correspondent predicts it will be vetoed.

ACTION ON OTHER HEALTH LEGISLATION

Health legislation approved by Congress and sent to White House included Fogarty bill (HR 9822), authorizing White House Conference on Aging, to be held in Washington in January, 1961, and HR 12876, authorizing another $90 million in federal grants, over a three-year period, to encourage construction and improvement of medical research facilities.

House commerce committee, before HR 12876 came on House floor, had deleted a section that would have made "multi-purpose facilities," including medical schools, eligible for financial aid.

Keogh-Jenkins retirement plan (favored by AMA and other professional groups) was rejected by Senate after objections by some senators that plan is discriminatory because it would benefit only the self-employed.

RESTRICTIONS ANNOUNCED IN MEDICARE TO KEEP PROGRAM WITHIN BUDGET

New restrictions in Medicare program are designed to enable program to be carried out within $70,246,000 appropriation provided for current fiscal year (a reduction of almost $20 million from last year's $90 million).

Among principal changes: Eligible military dependents living with sponsors will have to get clearance from commanding officers in order to qualify for civilian medical care or hospitalization. Costs of treating bodily injury not requiring hospitalization are disallowed, as are most outpatient services before and after surgery, all elective surgery, and treatment of nervous and mental conditions and "well baby" services.

In areas with two or more military hospitals, it is directed that a central clearing office shall be established on availability of beds and professional services (in such facilities). Last year many beds lay idle in military hospitals while dependents used more expensive civilian facilities.

BRIEF BRIEFS

House government operations committee has charged Federal Trade Commission with laxity in protecting public from misleading advertising claims for tranquilizer drugs and dentifrices. Committee advised FTC to schedule trade practice conference to work up codes of fair advertising practices for ethical drug manufacturers, and suggested similar measures with regard to dentifrice advertising.

Gordon M. Marshall

Calendar of Meetings

SEPTEMBER

7-11 American Surgical Trade Association, Shoreham Hotel, Washington, D.C.

8-12 AHA Institute, Dietary Department Administration, Bellerive Hotel, Kansas City, Mo.

9-10 AWH Workshop on Public Relations, Boise, Idaho

12-13 AWH Institute on Hospital Accounting, Hotel Multnomah, Portland, Ore.

15-16 AWH Workshop on Supervisory Training, Olympic Hotel, Seattle

15-16 Montana Hospital Association, Elks Club, Havre

15-17 AHA Institute, Disaster Planning, Adolphus Hotel, Dallas, Tex.

18-19 American Osteopathic Hospital Association, Northwest Institute, New Heathman Hotel, Portland, Ore.

22-25 AHA Institute, Evening and Night Nursing Service Administration, Sheraton-Lincoln Hotel, Indianapolis

25-26 AHA Institute, Hospital Insurance, Capitol House, Baton Rouge, La.

26-27 American Medical Writers' Association, Hotel Morrison, Chicago

28-Oct. 1 American Fracture Association, Oklahoma City, Okla.

29-Oct. 2 AHA Institute, Operating Room Administration, Sheraton-McAlpin Hotel, New York City

29-Oct. 2 AHA Institute, Medical-Social Workers, Hotel Radisson, Minneapolis

OCTOBER

2- 3 AWH Institute, Improvement Through Forms, New Concepts of Departmental Management, Surf Rider Inn, Santa Monica, Calif.

6-10 American College of Surgeons, Conrad Hilton Hotel, Chicago

8- 9 Indiana Hospital Association, Indiana University Student Union Building, Indianapolis

8- 9 Vermont Hospital Association, Hotel Vermont, Burlington

9-10 AWH Institute, Housekeeping, Food Service, Maintenance, Hotel Hilton, Albuquerque, N. Mex.

10-12 National Association for Practical Nurse Education, Regional Workshop, San Rita Hotel, Tucson, Ariz.

12-17 American Academy of Ophthalmology and Otolaryngology, Palmer House, Chicago

13-14 Oregon Association of Hospitals, Gearhart, Ore.

13-16 American Association of Medical Record Librarians, Statler Hotel, Boston

15-16 Washington State Hospital Association, Winthrop Hotel, Tacoma

15-17 Saskatchewan Hospital Association, Bessborough Hotel, Saskatoon, Sask., Canada

16-18 West Virginia Hospital Association, Daniel Boone Hotel, Charleston

17-18 American Rhinologic Society, Palmer House, Chicago

20-21 Idaho Hospital Association, Hotel Boise, Boise

20-23 American Academy of Pediatrics, Palmer House, Chicago

20-24 National Safety Council, Conrad Hilton Hotel, Chicago

(Continued on page 12)

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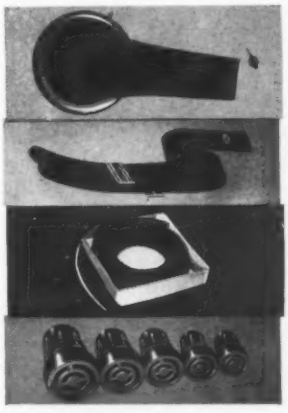

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CALENDAR OF MEETINGS

(Continued from page 10)

OCTOBER

21 Hospital Association of Rhode Island

21-23 American Dietetic Association, Trade and Convention Center, Philadelphia

21-23 Associated Hospitals of Alberta, Jubilee Auditorium, Edmonton, Alb., Canada

21-24 American Society of Anesthesiologists, Penn Sheraton Hotel, Pittsburgh

22-24 California Hospital Association, Biltmore and Miramar Hotels, Santa Barbara

23-24 Mississippi Hospital Association, Hotel Heidelberg, Jackson

23-24 Nebraska Hospital Association, Omaha

24-28 American Heart Association, Civic Auditorium, San Francisco

25 American College of Osteopathic Hospital Administrators, National Institute, Statler Hotel, Boston

26-29 American Osteopathic Hospital Association, Statler Hotel, Boston

27-31 American Public Health Association, Kiel Auditorium, St. Louis

28-31 British Columbia Hospital Association, Vancouver Hotel, Vancouver, B.C., Canada

31 AHA Financial Institute, Portland, Ore.

NOVEMBER

1- 8 American Society of Clinical Pathologists, Congress Hotel, Chicago

3- 5 Maryland-District of Columbia-Delaware Hospital Association, Hotel Shoreham, Washington, D. C.

6- 7 Oklahoma Hospital Association, Skirvin Hotel, Oklahoma City

7 Minnesota Hospital Association, Lowry Hotel, St. Paul

10-13 Interstate Postgraduate Medical Association, Public Auditorium, Cleveland, O.

10-14 American Association of Inhalation Therapists, Kingsway-Ambassador Hotel, St. Louis

12-14 AWH Institute on Hospital Administration and for Hospital Auxiliaries, Princess Kaiulani Hotel, Honolulu, T. H.

13-14 Arizona Hospital Association, Westward-Ho Hotel, Phoenix

13-14 Kansas Hospital Association, Baker Hotel, Hutchinson

14-16 Virginia Hospital Association, Hotel Roanoke, Roanoke

16-18 National Association for Practical Nurse Education, Regional Workshop, New Hampshire Highway Hotel, Concord, N.H.

16-20 National Society for Crippled Children and Adults, Statler-Hilton Hotel, Dallas, Tex.

17-18 International College of Surgeons, Mid-Atlantic Meeting, Homestead Spa, Hot Springs, Va.

16-21 Radiological Society of North America, Chicago

17-19 Association of Military Surgeons of the U.S., Hotel Statler, Washington, D.C.

18-20 AHA Institute, Disaster Planning, Ambassador Hotel, Los Angeles

(Continued on page 14)

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CALENDAR OF MEETINGS

(Continued from page 12)

NOVEMBER

19-21 Missouri Hospital Association, President Hotel, Kansas City, Mo.

20-22 American Association of Blood Banks, Netherlands Plaza Hotel, Cincinnati, O.

21-23 National Association for Practical Nurse Education, Regional Workshop, Willard Hotel, Washington, D.C.

DECEMBER

8-12 AHA Institute, Hospital Housekeeping, Ambassador Hotel, Los Angeles

1959 MEETINGS

January 27-30—American Protestant Hospital Association, Jefferson Hotel, St. Louis

January 27-29—National Association of Methodist Hospitals and Homes, Jefferson Hotel, St. Louis

February 4-5—AHA Midyear Conference of Presidents and Secretaries, Palmer House, Chicago

February 4-7—American College of Radiology, Chicago

February 9-11—Association of Operating Room Nurses, Shamrock-Hilton Hotel, Houston, Tex.

March 23-25—New England Hospital Assembly, Hotel Statler, Boston

March 31-April 2—Kentucky Hospital Association, Phoenix Hotel, Lexington

April 1-3—Mid-West Hospital Association, Municipal Auditorium, Kansas City, Mo.

April 6-9—Ohio Hospital Association, Veterans Administration Auditorium, Columbus.

April 8-10—Southeastern Hospital Conference, Atlanta-Biltmore Hotel, Atlanta, Ga.

April 16-17—Carolinas-Virginias Hospital Conference, Hotel Roanoke, Roanoke, Va.

April 27-29—Tri-State Hospital Assembly, Palmer House, Chicago

April 27-May 1—National Association for Practical Nurse Education, Netherland Hilton Hotel, Cincinnati, O.

May 4-7—Association of Western Hospitals, Hotel Utah, Salt Lake City

May 11-15—National League for Nursing, Philadelphia

May 12-14—Texas Hospital Association, Shamrock-Hilton Hotel, Houston

May 13-14—Upper Midwest Hospital Conference, St. Paul Auditorium, St. Paul, Minn.

May 20-22—Middle Atlantic Hospital Assembly, Convention Hall, Atlantic City

June 1-4—Catholic Hospital Association, Kiel Auditorium, St. Louis

August 24-27—American Hospital Association, The Coliseum, New York City

August 30-September 4—Second World Conference on Medical Education, Palmer House, Chicago

October 26-28—Maryland-District of Columbia-Delaware Hospital Association, Hotel Shoreham, Washington, D.C.

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*Howland, W. S.: Cardiovascular and Clotting Disturbances during Massive Blood Replacement, Anesthesiology 19 (2): 140-152 (Mar.-Apr., '58).

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SCANNING THE NEWS

(Continued from page 7)

all causes reaches a second peak from ages 45 to 64, males experiencing a rate nearly twice that for females. The ratio drops back to about that of the preschool level in the broad age group of 65 and over, the report notes.

Vascular Disease Rate No Greater in Executives

Contrary to the popular opinion among the men themselves — and their wives — high-pressure executives do not suffer greater tension and strain, with resultant physical breakdown, than do their less burdened, non-executive brothers, according to a five-year study of more than 2,000 individuals, by a team of New York physicians.

The male executives studied ranged from top executives (board directors, corporate officers, general managers) to minor executives (division heads, auditors, and others of lesser rank).

Of the executives, 12.3 percent had high blood pressure, as compared with 15 percent of the non-executives over 40 years of age. Arteriosclerosis was found in 7.8 percent of the executives, in 15.4 percent of the non-executives.

No significant relationship was determined between the incidence of heart attacks and the level of business responsibility.

The study was made by Richard E. Lee, M.D., New York Hospital-Cornell University Medical School, and Ralph E. Schneider, M.D., New York University College of Medicine. Among the reasons suggested for the less-than-expected executive rate was executives' use of escape valves, such as hobbies.

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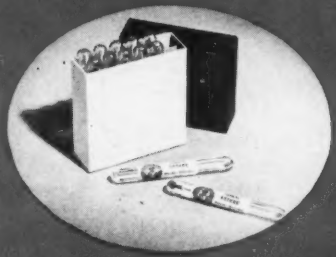

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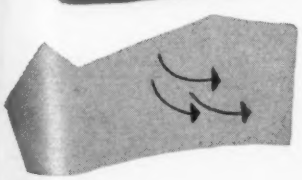

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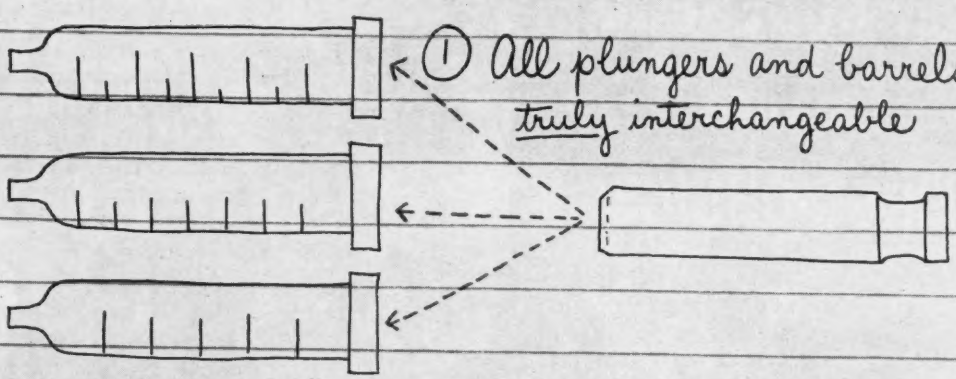

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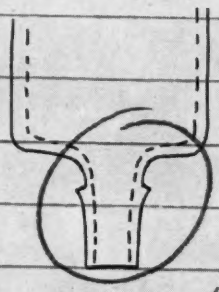

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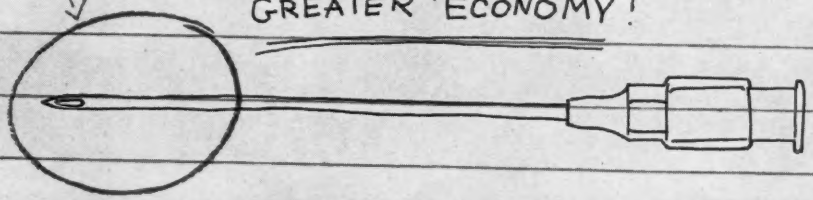

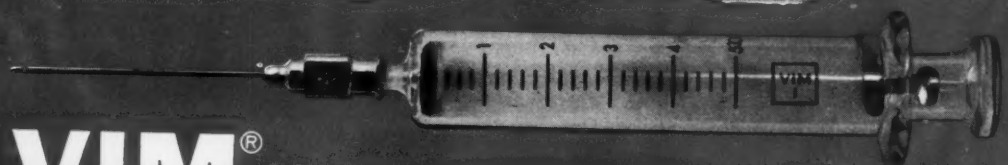

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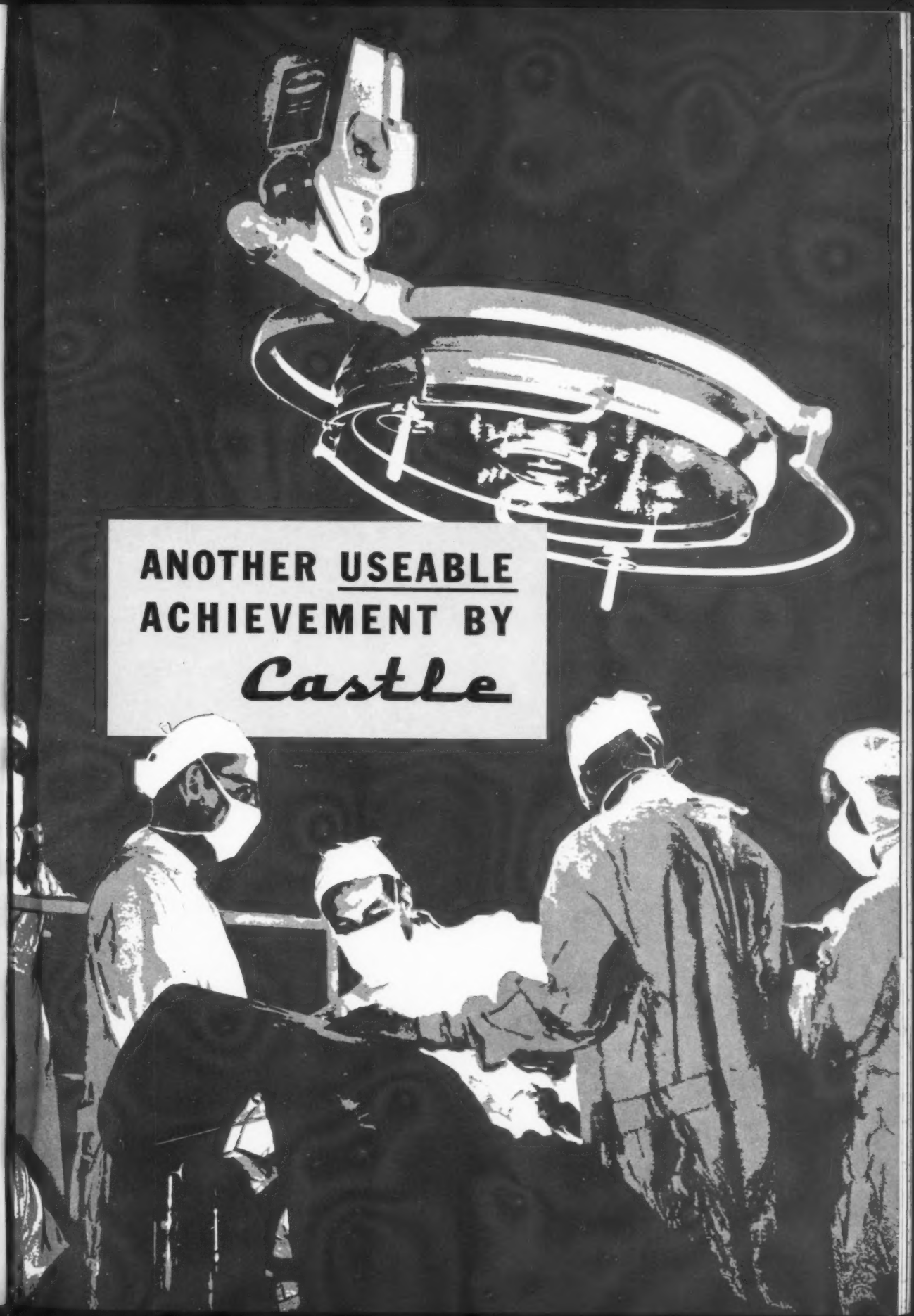
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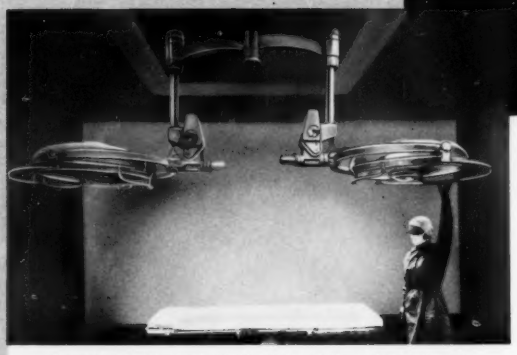

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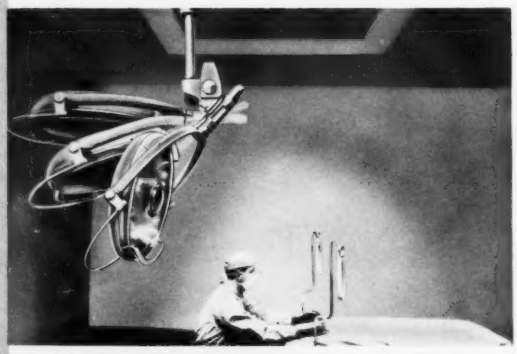

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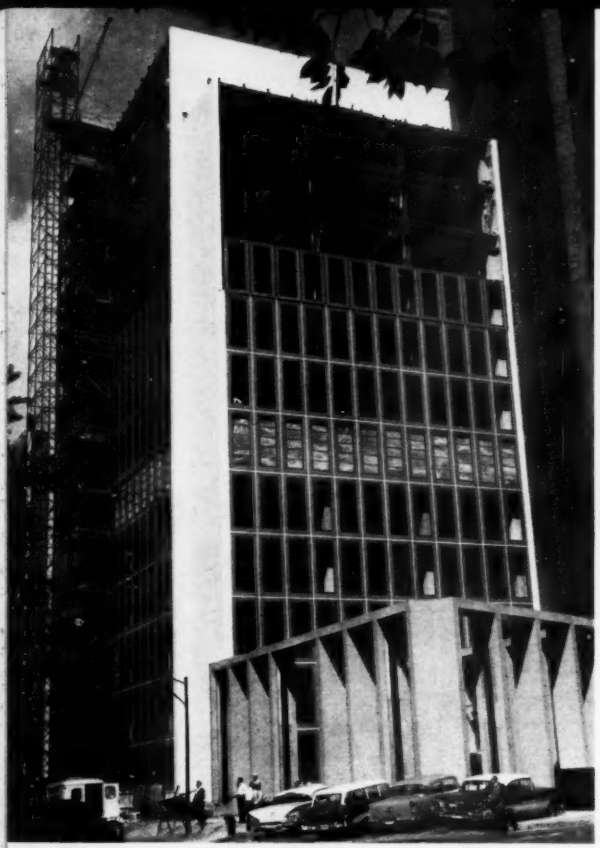
A H A

Edwin L. Crosby, M.D. (l.), AHA's executive director, accepts symbolic key to association's headquarters building from President Tol Terrell, at dedication ceremony on opening day of convention. Closed-circuit television made ceremony visible to conventiongoers at Amphitheatre. See page 18 for other pictures.

All photos by HOSPITAL TOPICS

60th annual convention
Chicago · August 18-21



AHA building, photographed on dedication day. Cost of constructing the 12-story building is approximately $7.8 million. Scheduled completion date is December 1, 1958.

Looking at commemorative plaque in lobby are (l. to r.): Tol Terrell, San Angelo, Tex., outgoing president, AHA; John N. Hatfield, AHA treasurer and recipient of AHA's 1958 Distinguished Service Award; D. F. W. Porter, M.D., Bathurst, New Brunswick, Canada, president, Canadian Hospital Association; Guillermo Almenara, M.D., Montevideo, Uruguay, president, Inter-American Hospital Association; and Frank S. Groner, Memphis, Tenn., outgoing president, American College of Hosptial Administrators.

"MUCH PLANNING, money, and hard work have set the stage for this occasion," George Bugbee, president, Health Information Foundation, New York City, and former AHA executive director, said in the dedication address for the AHA headquarters building August 18.

"Nothing I can say can adequately express our joint satisfaction at the great accomplishment this building represents. Rather let us reaffirm our high purpose . . . . This building grew because of the determination of the hospital people of this country that they would do everything possible to increase the effectiveness of care to the sick."

In picture below, Mr. Bugbee prepares to start his address. Standing at his left is Edwin L. Crosby, M.D., AHA executive director; at his right is AHA President Terrell. Chicago's Mayor Richard J. Daley, also a principal speaker, is seated at right.

Delegates Ask Independent Accreditation Commission for Hospital Nursing Schools

By Alice Clarke, R.N.*

"FOR everything there is a season, and a time for every purpose under heaven . . ." But August was not the appropriate season or time, nor was the place—the International Amphitheatre, located in the middle of Chicago's famous stockyards—the most desirable for the 60th annual convention of the American Hospital Association.

Nevertheless, some 7,000 registrants crowded into jam-packed, airless meeting rooms from August 18-21, to listen, perspire, swat flies, debate, and absorb the current points of view in the hospital world, while stoically attempting to ignore the frequent reminders of the convention's locale.

Outside the Amphitheatre meeting rooms, some 3,400 sweltering exhibitors, with glazed eyes and parched tongues, demonstrated their hospital wares to those who dared to linger under the liquefying lights.

But fortunately for posterity, it was in comfortable air-conditioned rooms that the AHA held its three sessions of the House of Delegates. It is easier to temper deliberations with equanimity when heat is only under a delegate's collar. And one of the two top issues before the House of Delegates, the National League for Nursing's accreditation program, has melted many a celluloid collar.

"Unhappy with a capital U" is the way one delegate expressed hospital administrators' feelings about nursing's controversial accreditation service. Another put it as graphically when he referred to the program as more "cussed than discussed."

Whether the cussing or the discussing was to blame, the delegates were in no mood for a diplomatic resolution couched in restrained language. They were determined that only a straightforward, unequivocal statement could be an effective stand against what they considered the evils of NLN's accreditation practices.

The more tactful but tentative statement prepared by the committee on nursing of the Council on Professional Practice would have requested the AMA and NLN to join the AHA in *considering* the establishment of an independent joint commission on accreditation of hospital schools of nursing. This was rejected for the stronger amended version of Thomas Hale, Jr., M.D., New York. The delegates unanimously voted:

"To request the National League for Nursing and the American Medical Association to join the American Hospital Association in establishing as rapidly as feasible an independent joint commission on accreditation of hospital schools of nursing, to be composed of these and possibly other groups, in order to spread the responsibility and financing for the accreditation program more fairly among those who benefit from the services of the graduates of hospital schools of nursing."

This action of the House nullifies the AHA statement of 1953 which endorsed the NLN accreditation program.

Justification for action had previously been given to the House by Russell A. Nelson, M.D., chairman, Council on Professional Practice, when he presented his report and asked the delegates to endorse the resolution recommended by the committee on nursing.

"The operation of the NLN's accreditation program is of increasing concern among hospitals," Dr. Nelson said. The major criticisms he listed were directed at the complexity of the accreditation process; vagueness of standards; the rigidity of requirements for school faculties; the increasing costs of the program, and the lack of a plan to spread these costs more equitably among all hospitals.

In addition to putting their stamp of approval on the nursing committee's recommendation, delegates voted to accept the review committee's recommendation that the House go on record as recognizing "that there is a pressing need for more professional nurses in most hospitals in the United States." (The Board of Trustees had not been as completely convinced of this as had been the review committee.)

The House also requested that the NLN review the December 31, 1959, dateline for provisional accreditation of hospital schools and defer the dateline until such review was completed. It criticized the NLN's proposed new accreditation fee schedule as being unreasonably high. The suggestion was made from the floor that the Board consider urging state hospital associations to encourage formation of established groups of hospitals operating schools of nursing in the various states.

The first evidence that there was not to be a collective meeting of minds on all accreditation resolutions came when a tie vote, 43-43, lost the motion that would have deleted the word "hospital" from the main resolution. If the motion had not been lost, the proposed joint accreditation commission would have had authority over not just hospital schools, but all schools of nursing . . . if it could get it.

The House also adopted as policy a statement prepared by the committee on nursing, "to re-emphasize the interest, support and responsibility of hospitals for the education of nurses and to re-emphasize support for the hospital school of nursing."

(Continued on next page)

*Editorial consultant, Hillsdale, N. J., and former editor, *R.N.*

AHA continued

In the 10-point explanation of policy following this introduction, AHA stated: It accepts responsibility for maintaining and increasing the numbers of registered nurses; has a community responsibility for nursing education and for improving the competence and quality of nursing through the promotion of sound educational programs; and believes hospital schools of nursing, as the largest educational system for nursing, are essential in meeting this responsibility.

This policy states the aim of the hospital school and places the responsibility for curriculum operation on the faculty of the school. It reiterates: AHA support of research in hospital school programs; its support of the principle of accreditation; its commitment to cooperate with the NLN and other interested nursing groups; and its support of better preparation of supervisory personnel, which category includes head nurses.

The new program for certification of foreign medical graduates came in for its share of discussion when a delegate voiced his concern and that of other administrators of small hospitals about the high number of failures (49 percent) among those taking the first examination given by the Educational Council for Foreign Medical Graduates.

Faced with the dilemma of losing AHA listing because of the presence of uncertified foreign medical graduates in patient-care situations and the alternative of no interns at all, the delegates urged the AHA to examine the present testing mechanism.

Of equal concern to delegates was the possibility of losing the certified foreign medical graduates because of another threat—the intern matching program. They requested that steps be taken to defer, if possible, the inclusion of the foreign medical graduates into the intern matching program until the foreign medical certification system had been further evaluated.

In the final hours of the session, the other top issue, a new policy statement in relation to meeting the needs for hospital care of the retired aged, was accepted. Its main points:

The AHA—

(1.) Is convinced that retired aged persons face a pressing problem in financing their hospital care.

(2.) Believes that federal legislation will be necessary to solve the problem satisfactorily, but has serious misgivings "with respect to the use of compulsory health insurance for financing hospital care even for the retired aged."

(3.) Believes that all possible solutions must be vigorously explored, including methods by which the dangers inherent in the Social Security approach can be avoided.

(4.) Believes that every realistic effort should be made to meet the hospital needs of the retired aged promptly through mechanisms utilizing existing systems of voluntary prepayment, but adds that it is conceivable, however, that the use of Social Security to provide the mechanism to assist in the solution of the problem of financing the hospital needs of the retired aged may be necessary ultimately.

This action rescinds the policy on health care of the aged which was passed in 1955. The 1955 policy recommended federal grants-in-aid to the states on a variable matching basis. This plan was not flexible, in that it limited government participation to "grants to states to assist in subsidizing voluntary hospital prepayment for the aged."

The current action on policy was also taken with the idea of preventing the possibility of a purely governmental solution to the problem of hospital care for the retired aged (Forand bill, H.R. 9467).

The fifth point in the policy developed by the Council on Government Relations stated that legislation should

Crowds wait at day's end for bus rides to hotels in downtown Chicago. Coat-carrying man gives idea of prevailing weather.

be devised to strengthen voluntary prepayment systems, and listed the following suggested criteria for legislation in this area:

It should provide essential hospital services, exclude nonmedical custodial care, be restricted to unemployed persons over 65, emphasize individual responsibility, and make application of a means test unnecessary for obtaining benefits.

It should be based on the service principle, and provide benefits of such a nature as to "remove the major economic barriers to hospital care for the retired aged." These benefits should be made available through nonprofit prepayment insurance plans.

Hospitals should be paid in full for the cost of the care given. The patient should have free choice of physician and hospital. Such a program should not provide services in facilities operated by the federal government. It should provide "reasonable criteria" for determining a hospital's eligibility to participate, but the federal government should be precluded from interfering in the administration and operation of any hospital.

The program "should permit and encourage continuous adaptation to new knowledge in the provision of services."

Although only one dissenting vote was cast against it, the statement announcing the association's current position on meeting the needs of the retired aged did not go through the House without opposition, nor did it emerge in its pristine state.

The opposition criticized the statement for its reference to the means test, and to the potential use of the Social Security mechanism. One delegate also expressed the fear that the AHA, as a co-sponsor and participating organization of the Joint Council to Improve the Health Needs of the Aged, would hamper the Council if it solidified its position.

The explanation that the association program was a prepayment proposal, and therefore a means test requirement by the federal government was inappropriate, seemed to satisfy the delegates. They were also appeased by a rewording of the sentence, "The AHA *believes* that the Social Security mechanism may be necessary ultimately . . ." to "*It is conceivable* . . ."

In answer to a defeated resolution to strike out the entire Social Security reference, the delegates were told that this deletion would "tie the AHA hands and put the association on the fence."

Whether the association has climbed down off the fence with this statement is a moot question.

Accreditation: NLN's Side of Story

EDITOR'S NOTE: The day after AHA delegates approved a resolution requesting a joint commission for accreditation of hospital schools of nursing, two representatives of the National League for Nursing reported on progress of the NLN's accreditation program. Third member of the instructional conference panel was an administrator who has attended two meetings of the NLN board of review of applications for accreditation.

Although speakers made no mention of the delegates' decision, some of their comments were obviously rebuttals to criticisms of the NLN program. Here is the NLN's side of the accreditation controversy.

Accreditation, Improvement of Schools Are Objectives of NLN Program

Service Attempts to Aid School In Developing Own Curriculum

We all agree that we need nurses, and that we need good nurses. And good nurses are the product of good education. Why accreditation? Obviously, the process of accreditation is ultimately supposed to give better service to society on the part of practitioners whose program of education is being accredited.

The immediate objective, of course, is the accreditation of a program of education which prepares the practitioner, and therefore sound education is the immediate objective of any accrediting program. The League, however, had another objective: improvement of the schools of nursing wherever nursing education was being carried out with accreditation as a goal toward which schools would work. As the process developed, it had to carry out that objective.

Through the process of accreditation a school is constantly studying itself, and this practice attracts good students through counseling. By and large, what is going on in general education has a very close relationship to what has motivated the development of the League's program.

The name of the school on an accredited list undoubtedly attracts better candidates and more candidates. That has been proved as the list of accredited schools has grown. Also, perhaps having early accreditation gives a sense of justifiable pride and togetherness to the administrators.

It is important to know the belief on which the process of accreditation has been built. From the beginning of the program, there was an interprofessional executive group. Accreditation concepts were developed with a great deal of help from the individuals who made up the first joint committee for the unification of accreditation policies. The present executive committee is interprofessional, with five members appointed by the American Hospital Association.

It was not the purpose to encourage all schools to be alike, but to urge each to develop its own education according to its own objectives and the thinking of its own faculty and administrators. It was considered that in the process of developing objectives, the schools' strengths and weaknesses could be weighed

(Continued on next page)

Following panel discussion on hospital disaster planning, Robert L. Stolz (l.), assistant administrator, Halstead (Kans.) Hospital, and Mary Frey, director of nursing, Augustana Hospital, Chicago, question panel member John N. Hatfield II, assistant administrator. The Burlington County Hospital, Mount Holly, N. J. In background is panel moderator, B. I. Burns, M.D., medical superintendent, General Hospital, Kansas City, Mo.

against one another, and a strength would often counterbalance a weakness. In the judgment of the National League of Nursing's board of review, that has been exactly the basis upon which the schools have been evaluated.

A great deal has been said about the point system of arriving at accreditation. The executive committee believed that that was not the best approach to the ultimate goal—improvement of nursing education. It felt that the accrediting service should help the school to develop its own program as it conceived it. The process of accreditation should be, as much as possible, a stimulating, growing kind of experience for the faculty. —*Marion W. Sheahan, R.N.*, director, Division of Nursing Services National League for Nursing, New York.

Tells Assumptions Underlying NLN Program of School Improvement

42% Fully Accredited in August, 1958; 35% Have Provisional Accreditation

The NLN has sought and will continue to seek to provide assistance to the schools which will enable them to effect improvement in their educational programs. The assumptions underlying the broader program of school improvement are:

Perhaps the most important—there is a need for nursing schools offering diploma programs and for schools which offer other types of programs if there is to be a supply of nurses to meet the needs of patients of this country.

There is a need for schools offering diploma programs and other schools to improve their programs so that graduates will give better care. If schools are to be improved, work toward this end must be done by the individual schools at the community level through critical analysis and self-help. Improvement is possible in most state-approved schools, regardless of size and location. All such schools should be encouraged to participate in a school-improvement program on a continuing basis.

Have the diploma programs improved themselves in using accreditation? In the fall of 1949, 123 diploma programs in nursing—approximately 12 percent—had full accreditation. When temporary accreditation came along, it was granted to 580 diploma programs in 1952.

Approval of additional schools in the spring and fall of 1952 raised the total of programs with temporary accreditation to 601, or 55 percent of all diploma programs. At the end of 1952, 154, or 15 percent of diploma programs had full accreditation.

In August, 1958, there were 395 diploma programs fully accredited, or 42 percent of the total. Thirty-five percent more—326 programs—have provisional accreditation.

Have individual diploma programs critically analyzed themselves and moved forward to self-evaluation and self-help? Yes. Beliefs about nurses and nursing education have been much more clearly defined; objectives of the school and the curriculum have been stated in more meaningful and realistic terms.

Faculty groups have become better qualified. Nursing-school faculties have assumed responsibility for developing learning experiences and organizing curriculums which are in keeping with the objectives set down. Curriculum offerings have been scrutinized in terms of content and sequence correlation.

Has the NLN offered programs to assist hospital schools in improvement? Again, yes. After temporary accreditation was granted to schools and visits were made in 1952 to assist schools to improve, 19 conferences were held in 1952 in all sections of the country.

In 1953, 19 more conferences were held. This year also saw the beginning of consultation services being made available to schools, as a direct result of requests for such services.

In 1954, the League intensified its efforts to help programs which were not fully accredited to improve more rapidly with financial assistance from several foundations. A free consultation visit was given to all temporarily accredited and nonaccredited basic schools which desired it, and these schools were invited to attend an annual statewide conference for further discussion of their individual and mutual problems. Of the 747 schools temporarily accredited and nonaccredited, 672 elected to participate.

As a result of consultation visits to the schools in 1955, 1956, and 1957, those of us working with the schools had a definite feeling that many of them were attempting to be perfect, and because of this were hesitating to apply.

In 1955, the first draft of the criteria for the evaluation of diploma programs was studied by the Council of Member Agencies, and member schools were invited to involve their faculty and others interested in diploma programs in nursing in a comprehensive review of these statements, and to return their comments, suggestions and criticisms.

In 1956, the complete tentative statement was again brought to this group. In 1957, copies of the statements were sent to all schools for review and discus-

sion and suggestions. These statements were accepted in May, 1957, by the membership of the department.

By the end of 1958, it is anticipated that 46 percent of the diploma programs will have achieved full accreditation. It is our hope, as well as our calculation, that approximately 545, or 58 percent of all programs offered by hospital schools will be fully accredited by the end of 1959.—*Frances K. Peterson, R.N.*, assistant director, Department of Diploma and Associate Degree Programs, National League for Nursing, New York City.

Praises Comprehensive Survey Reports; Urges More Administrator Interest

Says Program Has Stimulated Schools to Self-Improvement

As a representative of the American Hospital Association, I have attended two meetings of the board of review for accreditation applications, in New York City, in 1957 and 1958. These two meetings have left me with a strong conviction of the value and necessity of maintaining a close liaison between the AHA and the National League for Nursing.

I was quite impressed by the objectivity of the board's decisions. I saw no instance of intent to close any school of nursing or to promote the interest of any school or group of schools at the expense of any other school or groups. The comprehensiveness of the survey reports seems to me to be the result of an effort to give every school credit for every possible element of strength in its program, and also to disclose any elements of weakness which could be improved so as to provide a better education for the student and sense of responsibility which must be assumed by the professional nurse of today.

I was requested to make some practical suggestions to administrators of hospital schools. They are:

(1) The accreditation program of the National League for Nursing is based on the theory that a school of nursing should be a school, that is, an educational institution. The hospital administrator who accepts this as a basic principle in planning for a nursing school can greatly accelerate the progress of his school toward full accreditation. It appears to me that any administrator who holds to the theory that his school of nursing is operating for some other purposes makes it difficult for the school to attain full accreditation.

(2) Administrators might very well become better acquainted with schools. I am informed that only about one-third of the hospital administrators have attended the open readings of the survey reports on their own schools, at the concluding session of each week-long survey program. Since the purpose of this reading is to give the faculty an opportunity to correct any errors of data or misinterpretation, so that the reports may be completely accurate in their presentation of the school's program to the board of review, it would seem that the administrator could justify spending an hour to attend this reading.

(3) Many of the survey reports contain school budgets which are quite unrealistic. Figures submitted by different schools are not at all comparable. Few report an accurate picture of income and expense. Uniformity in accounting practices must be developed

(Continued on next page)

At left: In a happy mood at President's reception were (l. to r.): Edward P. Toner, administrator, Maluhia Hospital, Honolulu, Hawaii; John P. Garrison, assistant administrator of medical institutions, Alameda County Hospitals, Oakland, Calif.; and Robert B. Carey, administrator, Alliance (O.) City Hospital.

At right: Having collected happily tired daughter, Julia Maria, from children's social hour held concurrently with reception, George R. Bailey, Burrell Hospital, Roanoke, Va., and Mrs. Bailey, wait for elevators.

At right: Man with monkey was big attraction for young children at children's social hour. Older children danced to records.

Below: T. Stewart Hamilton (l.), M.D., executive director, Hartford (Conn.) Hospital, stops to chat at reception with Ray E. Brown, Mrs. Brown, and their daughter, Margie. Mr. Brown, superintendent, University of Chicago Clinics, and a past president of AHA, was named ACHA president-elect.

"Some may say that the public wants too much. We must remember that hospital, medical and economic forces have effectively established new and exciting approaches to health care and payment for the patient. It is natural for a free people to demand and expect the best, always, of anything their vibrant freedom discovers.—*Tol Terrell*, outgoing president, American Hospital Association."

Approaching the Amphitheatre from the Stock Yard Inn.

AHA continued

before financing of a school of nursing can be put on a sound basis. This problem can be solved by the co-ordinated endeavor of hospital administrators and educational leaders.

(4) The administrator, in my opinion, should be more careful in distinguishing between the accreditation program of the National League for Nursing and the economic security program of the American Nurses' Association. They are two separate and distinct programs, and there appears to be no relationship between the two.

(5) It is my personal opinion that the schools will benefit by having agency membership in the National League for Nursing, and actively participating in the meetings of the Department of Diploma and Associate Degree Programs.

It is my opinion that if the present trend continues, more than half of all the diploma schools in the United States will be accredited by January, 1960, and that two-thirds of them could be accredited by that date if they would make a sufficient effort at self-improvement.

My experiences in meeting with the board of review have given me a firsthand view of the tremendous improvement in the quality of nursing education in the diploma schools, which has taken place over the past 10 years. Schools large and small have been stimulated to self-improvement as never before in history, and have nobly responded to the challenge presented by the accreditation program.—*The Rev. W. C. Perdew, D.D.*, administrator, Bronson Methodist Hospital, Kalamazoo, Mich.

> In large-scale hospital operations, some equivalent of collective bargaining or organized employee representative spokesmanship with real powers, is essential to equity, fair play, and effective two-way communication. And only as there is the economic security, sufficiency and status of worker-group by profession, craft or job, is it possible to call forth the attitude of mind, the motive of creativity, from which improvement of work quantity and quality can be appealed for with any likelihood of success.—*Ordway Tead*, vice-president, Harper and Brothers, New York City, in Arthur C. Bachmeyer Memorial Address before the American College of Hospital Administrators.

Discussion

Q. Could there be a short clarification of accreditation costs?

MISS SHEAHAN: The cost covers not just the survey of the school, but the total improvement program. The bulk of the income comes from the agency getting the service. The cost reflects all materials used, the meeting of the council, the consultation, the voluminous correspondence that must be handled from the office, as well as the actual visit to the school every six years after the original accreditation visit, and the expense involved in the review of the application.

Q. Do you have any suggestion whereby the cost to the specific school might be reduced? Is any sharing of the cost contemplated, or financing by some foundation or any other source, or do you think the cost should be directly assessed against the schools?

MISS PETERSON: To date, support of the program has been given by foundations, but we know that we will not be able to receive this support after the end of this year. At present, it is contemplated that the Council of Member Agencies or the schools within the Council would have to carry the cost of this program.

Q. It seems that the three-year diploma program is getting obsolete. Should the three-year hospital program plan for reduction in the time element?

MISS SHEAHAN: Personally, I don't believe any

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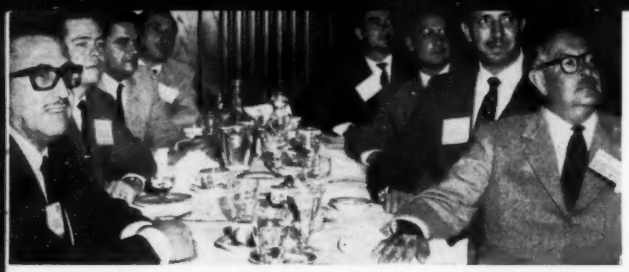

The luncheon for international guests attracted hospital and allied personnel from such far distant points as Formosa and Australia, who came to renew old acquaintanceships, form new ones, and exchange ideas—with mutual interests successfully hurdling any language barriers. Conventioneers from south of the border were represented in force, including this table of guests from Mexico. Clockwise, they are: Carlos Barrena, M.D., Mexico City; Alfredo Avelar, M.D., Guadalajara; Albert Castro and Fernando Pena, both Mexico City architects; German Lelo De Larrea, M.D., Lauro Vivaldo, M.D., and architects Augusto Perez Palacios, and Eustaquio Escandon also of Mexico City.

change should be made until we know where we're going—until the report comes out next year on the junior college associate degree programs. It seems to me to be most unwise for three-year schools in hospitals to make changes until they have made a careful study of their programs and know exactly where they are going.

DR. PERDEW: Hospital diploma schools constitute the greatest present source for the education of professional nurses; at the present time, they educate approximately 85 percent of all who are being educated. I don't consider that a program so successful in its results and now undergoing such striking improvements is in any sense obsolete.

Q. Does the National League think that the central area diploma schools would find it easier to improve educational standards? If so, should they be sponsored by hospitals or community?

MISS PETERSON: This type of organization has proved rather successful in certain areas of the country. Pooling of faculty members who may have been employed in a small individual school into the faculty of one school *does* seem to provide more and better prepared faculty.

MISS SHEAHAN: I emphasize again that no change should be made, no centralization should be done until there is more study of the area and the cost and the desirability of location. It is expensive to produce faculty and spread them as far as they can go effectively.

Q. What will become of schools which are not approved by the December 31, 1959, deadline?

MISS PETERSON: These schools can always apply for accreditation; the doors are open. As improvement takes place, and faculty members decide that their school is ready, all the school has to do is submit a written application. The usual procedure will be followed.

Q. Is a formal budget of the school mandatory?

MISS PETERSON: It is not mandatory; it is preferred. Why? We know that education of any kind costs money, and so that program has to be organized and supported. Certainly, any sound educational program has to give some evidence of financial support, which will provide for its continuing operation and development.

Q. Discuss the merits of an organizational plan under which one person is director of both the nursing school and nursing service, versus a plan under which there is a director of the school and a separate director of nursing service. Which is favored by the NLN?

MISS PETERSON: The NLN does not favor either of these. The school as an individual entity has the right, privilege, and responsibility to set up the organizational pattern which best suits its needs. In the majority of schools, the director of nurses is responsible for directing both the nursing service and nursing education. A few schools have full-time directors, but this type of organization has come about after much study and consideration of changing from the other pattern, careful consideration being given to the understanding which is needed, consideration of the preparation of the individuals who assume full-time responsibility of service and education. Many schools who have studied the advisability of such a change have decided not to change.

Effective Planning Essential To Avoid External Controls

Need for Identifying Function Of Hospital in Modern Society

The growing responsibility of the hospital as a community institution is compelling external controls from government and from other voluntary agencies. The check against forced controls is effective co-ordination by hospitals. This can only be achieved by effective, broad, and co-operative planning.

As members of a profession concerned with the health of a democratic people, we are charged with the responsibility of proving that the health needs of a large population can be met by voluntary co-operation among independent social organisms, without the domination of an all-powerful state apparatus and without loss of freedom to dissent.

The able administrator must be a good planner. He must constantly evaluate and study in terms of the philosophical, the socio-economic, and the professional.

Planning is a broad responsibility of trustees, staff, and department heads. The role of the administrator is to co-ordinate. He should provide the broadest possible participation at the community level for planning. It is sometimes difficult to get the board of trustees to understand the need for effective planning. They must be willing to let the administrator assign problems and delegate authority to others. Details and systems must be related to the hospital's objectives and role in the community.

It is necessary to identify the character of the hospital in modern society. The spectrum of ideas as to function ranges from the concept of the hospital as

the brokerage house for the sale of professional services to that of the hospital as the dynamic center in which all elements of services are provided to the society. The role of the hospital is subject to many influences:

—Population, which in turn is subject to many social changes caused by such factors as mobility and increased longevity. As these factors change, the role of the hospital changes. The administrator must be ready to assess the population changes and their significance.

—Medical prepayment plans, which have a profound effect on the nature and demands for medical care by the public.

—Economics of medical care. Who is receiving care and who is not? Are there gaps in community-wide medical services? The effective administrator-planner must be alert to trends.

—New developments in medical sciences. How should the hospital plan for disposal of radioactive wastes? What are the needs and demands for blood banks and psychotherapy?—*Richard J. Stull,* vice-president, medical and health sciences, University of California, Berkeley.

Hospital Planning Should Be Part Of Over-all Community Planning

Needed to Avoid Unnecessary Duplication of Facilities

Hospital master planning should be an inherent part of the total planning in the community. The need for a broad, community-wide plan was demonstrated by results in Detroit. Studying needs, co-ordinating activities, and avoiding unnecessary duplication resulted in reducing estimates for needed construction from $110 million to $80 million.

The "urban sprawl" has created the need for master planning. Industry, which is reluctant to support unnecessary hospital duplication, has developed the pressure. Master planning must be a continuing process. The emphasis should be on planning, not a plan. The master plan is not a static document. It is a "journey," not a "destination."

People doing the master planning for hospitals in urban communities must have a strong civic interest, "a thick hide," and an ability to be flexible.

Feasibility of urban master planning for hospitals is often questioned because of the existing patterns and investments and the lack of authority to compel compliance. The urban hospital planning council must consider the needs and resources of surrounding areas as well as the urban area itself. A review of present facilities must be made, in order to provide a document which will act as a guide for the community.

While urban hospital plans usually begin with a bed-need formula, this is generally adjusted to meet local conditions. Such factors as mental health programs and resources and Blue Cross membership and services are usually taken into consideration.

Community acceptance of the master plan is of primary importance. Panel discussions with active audience participation are an excellent tool for educating the public about the plan. The composition of the "council" is also important in obtaining acceptance. Ideally, it should include representation from hospitals, the medical profession, and the public. It is a good idea to have a leading journalist as a member of the council.—*Jacques Cousin,* executive director, Greater Detroit Area Hospital Council, Inc., Detroit; *Hayden C. Nicholson, M.D.,* executive director, Hospital Council of Greater New York, New York City; *Nathan J. Stark,* chairman, planning committee, Kansas City (Mo.) Area Hospital Association; and *Helge Westermann,* architect, A.I.A., New York City.

Lawyer Welch Deplores Rise Of "the New God Speed"

Utters Plea for Printed Page— As Vital to Ideas, Culture

We seem to live in a crisis state—the new god is Speed. We get our information, so to speak, on the run. It brushes the surface of our minds, but it does not really penetrate. We become aware of some disaster and say to a friend, "Did you hear about the explosion or the murder?" But a thoughtful idea, a national policy, or a bit of philosophy, to say nothing of something of true literary quality, never reaches the core of our minds.

Worse than that, there is no time to consider what is important, and what is unimportant. Everything is in the same tone of breathless urgency, until nothing is thought to be really urgent.

There is, today, no time for thought, for reason, for forming personal judgment. All of which means that there is no substitute for the written page and for the intellectual processes which one must happily engage with the printed page before the eye and with that priceless ingredient—a little leisure, a little indolence, a little time to think.

I am not saying that I wish to banish radio and television as news media. But we should not let electronics totally eclipse our resorting to the printed page. Our whole culture, our whole history is recorded on the

(Continued on next page)

Air defense command administrators combined AHA with their own two-day meeting in Chicago. Here, attending federal hospital luncheon, are: Maj. Stanley Rhodes (l.), executive officer, 328th USAF Hospital, and Maj. R. J. Preston (r.), director, medical administration, Central Air Defense Headquarters, both of Richards-Gebaur AFB, Mo., and 1st Lt. John P. Lensch, medical services administration, 14th USAF Dispensary, Minooski, Vt.

From this angle, convention site looks more like a peaceful country garden. At right is the Stock Yard Inn, with architecture seemingly patterned after that of Shakespeare's cottage in Stratford-on-Avon. Two administrators stroll through the garden under the canopy which covers the walk from the Amphitheatre to the old hotel, traditional headquarters for cattlemen bringing their livestock to market.

NEXT MONTH

Are Hospital Schools Doomed?

Also — TOPICS reports on more AHA instructional conferences

printed page. Only in print can ideas, a history, a culture be stored and thereafter examined, weighed, and used as a guide to the future.

In a world which worships the false god Speed, one thing remains constant—the speed with which the human eye and mind can read and digest what is read.

I am suspicious of the quality of citizen which will emerge from homes with dining rooms in the kitchen far removed from the shelf which holds the unabridged dictionary and a set of encyclopedias. The dictionary should appear at dinner as often and with as much nourishment as the roast beef or the hash with a dropped egg.

There is no reason that the conversation at dinner should not be equal to Mamma's cooking when it comes to quality. The home that talks only of the trivia could produce citizens whose interests will not rise above the trivia.—*Joseph N. Welch*, senior partner, Hale and Dorr, Boston.

California Liability Insurance Program Results in 20% Premium Reduction

Number, Severity of Claims Reduced; Hospitals Share in Dividends

By co-operative effort, the 134 hospitals in the California group liability insurance program have reduced their premiums by 20 percent and obtained a 30 percent dividend in a three-year period.

Malpractice and patient accident claims were reduced from one for every 18 beds, in 1954, to one for every 36 beds in 1956. Also, the severity was reduced. The major reduction was attributed to standing orders which require bed rails for all patients over 50, eye patients, sedation patients, and postsurgical patients. Most falls from beds occur between 11 p.m. and 2 a.m. Those who climb over bed rails are usually not as seriously injured as those who fall out because there is no bed rail. The reason is that the patient is hanging on to something.

In a three-year period, medication claims have been cut in half. They could be further reduced if the confusion in orders between apothecary and metric systems could be avoided by a single standard.

Among the many benefits of group coverage is the availability of excellent data from one central source. Another benefit is an opportunity for the small hospital to share in dividends. Dividends are not given by insurers unless the annual premium exceeds $2,500. In a group program, however, all hospitals, regardless of size, share in dividends.

A single carrier for a large number of hospitals in a group program can concentrate on developing prevention programs and engineering studies of accidents, as well as specialize in problems unique to hospitals. Group coverage is a great deal cheaper because there is no sales overhead for the carrier, and the risk is improved because of assurance of co-operation.

The group program in California provides data on 15,000 accidents in hospitals a year. It is of utmost importance that every accident be reported. The greatest hazard is not in the accident itself, but in not reporting it. Experience has demonstrated that there should be two accidents reported, per bed, per year.

One-half of one percent of salaries is spent annually on compensation coverage. Eighty percent of all claims for compensation are for strains from lifting and for slips and falls. Most nursing personnel do not know how to lift patients. The average collection for strains from lifting is $772.50. Such injuries are preventable, but nursing personnel need training in body mechanics. This training can be provided by the carrier, who, by terms of all contracts, agrees to provide such services.

Most housekeepers do not know how to wax floors. They either get too much or too little wax on the floor. Slippage is measurable and can be determined by the engineering department with a handkerchief and a sandbag.

Everyone in the institution should be trained to pick up items on the floor. No one is too good—from the president of the board to the lowest scullery maid. The same thing should be true of spillage. If it cannot be mopped up by the person noting the spillage, that person should remain at the spot, warning off others until it is wiped up.

The importance of the safety committee cannot be overemphasized. Hospitals with safety committees had an average of six percent in savings on compensation cases over hospitals without such committees.

Many accidents can be avoided by fixing responsibilities for: identifying patients going to surgery; checking the chart to see what procedure is to be done; obtaining signatures in cases in which they are required; determining that consultations are made where necessary; obtaining tests for sensitivity to drugs and anesthesia; removing dentures before surgery; and determining that the right type of blood is ordered and delivered for a patient.—*James E. Ludlam*, Los Angeles, legal counsel, the California Hospital Association.

Over 1,100 Foreign Physicians Signed For Second ECFMG Test This Month

152 of 298 Passed First Test; 77 Who Failed Will Repeat Exam

A total of 1,146 foreign physicians have signed up for the second screening examination of the Educational Council for Foreign Medical Graduates, to be given this month. Thirty-one examining stations have been set up around the world. Seventeen stations in this country will examine the 931 with United States addresses.

Of 298 students who took the first screening examination, given March 25, 152 passed. Only one person failed the English test.

Those who fail are permitted to take the examination a second time, provided that they pay the $35 fee, but a third examination will be permitted only if students can show that they have been taking additional work which might make them better qualified. Seventy-seven who failed are repeating the examination in September.

The seven-hour, written examination includes 360 multiple-choice questions—35 percent on medicine; 25 percent, surgery; 15 percent, pediatrics; 15 percent, obstetrics and gynecology; and 10 percent, basic sciences. All questions come from the large pool of questions accumulated by the National Board of Medical Examiners. Examinations are machine-graded and the cut-off line determined. On the first examination, 75 percent was the cut-off line.

The student's ability to understand spoken English and to write English is tested in a simple way. A case history is read off, and students are then asked to write up a summary, just as they would do in the hospital.

Examinations in 1959 will be given on February 17 and September 22.

Our "target date" is January 1, 1960. We hope that no new appointments will be made after that date to foreign graduates who have not been certified by ECFMG or licensed by a state board. By July 1, 1960, we hope that no hospital will have uncertified foreign medical graduates on its roll.—*Dean F. Smiley, M.D.*, executive director, Educational Council for Foreign Medical Graduates, Evanston, Ill.

7,622 Foreign Physicians Training In 821 U.S. Hospitals in 1957-58

There are 7,622 foreign physicians training in United States hospitals in 1957-58: 2,079 in internships and 5,543 in residencies. They are found in 821 hospitals. The largest number is from the Philippines—about

(Continued on next page)

Wendell H. Carlson (l.), administrator, West Suburban Hospital, Oak Park, Ill., and Virgil W. Nelson, executive director, Lutheran Deaconess Hospital, Chicago, inspect a relic from the days of the old West. The stagecoach stands just inside the entrance to the Stock Yard Inn.

1,600. Approximately 90 different foreign countries are represented.

The program of the Educational Council is a sincere effort to improve a situation that was becoming increasingly difficult. The list of foreign medical schools, first presented by the Council on Medical Education and Hospitals in 1950, was never intended to be a list of approved schools. It was prepared to indicate that the council had sufficient information on the type of training presented to determine whether it was comparable to training in our schools.

However, the use of the list by state boards and hospitals was discriminatory, and it became obvious that some other method was required. The 1950 list is being withdrawn on January 1, 1960.

The State Department is interested in the ECFMG program, because some foreign graduates have gone home from the United States and complained that they were getting inferior training (possibly in unapproved hospitals)—that hospitals were using them for service.

The American student who goes to a medical school abroad will be subject to ECFMG in the same way that any other foreign graduate will be subject to it.—*Edward L. Turner, M.D.*, secretary, Council on Medical Education and Hospitals, American Medical Association, Chicago.

Discussion

Q. If a hospital gets less than 50 percent of the interns needed from the matching program and fills its quota with foreign interns, will the intern program be adversely affected?

DR. TURNER: No. After 1960, of course, it is anticipated that such interns will have been cleared through ECFMG.

Q. What is the reaction of foreign medical schools to ECFMG?

DR. SMILEY: In general, I would say it has been very good.

Q. In some foreign schools students complete their training in December. Can a student take the qualifying examination in September, prior to graduation?

DR. SMILEY: Yes—if he has a letter from his dean indicating that he is likely to pass. He does not receive a certificate prior to his graduation.

Q. What effect will the examinations have on the number of foreign medical graduates in this country, Dr. Turner?

DR. TURNER: It's hard to say. The number may be initially reduced. Undoubtedly, some individuals will remain in their native countries and not come over here. I believe, however, that in the long run the program will stimulate the higher caliber of foreign graduates to come to this country.

Q. Will the ECFMG give the candidate a certificate saying he has passed, or will the hospitals be notified? What system is followed?

DR. SMILEY: It takes about two months to evaluate results. We meet approximately two months after the examination. All those who passed are notified by letter. State medical boards are also notified of those who passed. A certificate is sent somewhat later to the qualifying graduate.

Q. A foreign graduate beginning a residency in July, 1958, will not have completed his training by July, 1960. Will he be affected?

DR. TURNER: No—unless he planned to try to qualify for a state board examination, and wanted to remain in this country.

Q. If a foreign student starts his training January 1, 1959, and has not taken the examination, can he take it in this country?

DR. SMILEY: Yes—but if he wants to emigrate, he must return to his country after his training for at least two years to get a permanent visa.

Q. Will American University of Beirut students be required to take the examination?

DR. SMILEY: The entire 1959 class of the university will take the examination in September.

Q. At the present time my hospital prides itself on having no foreign graduates on its house staff. We believe their presence might hurt our recruitment of U.S. graduates. Do you think U.S. graduates will know enough about ECFMG not to be prejudiced against foreign graduates?

DR. TURNER: If the hospital has a good program, the presence of foreign medical graduates is certainly no detriment. There are very few teaching institutions which do not have some foreign graduates as residents or even fellows, along with the domestic graduates.

Q. What program could be developed to get the foreign medical schools interested in U.S. standards?

DR. TURNER: I don't believe their programs should be patterned after ours. Are they training physicians primarily for export, or to serve their own needs? The customs in European countries are different from ours. Their program of medical training has been designed on the basis of their needs; ours has been designed to meet our needs. Basically, good medicine should be international—but the approaches are different.

Q. Are steps being taken to avoid poor education and exploitation of foreign students?

DR. TURNER: This is an important question—no more important for foreign students than for our own graduates. The answer depends largely on whether the doctors and faculty are sympathetic. Exploitation sets in when hospitals are looking for a cheap pair of hands.

I believe we have a great responsibility to share our medical knowledge with representatives of other countries. We want to be sure that we share the right information and that we choose the right types of individuals.

(Continued on page 32)

ACHA convention dignitaries on stage appear to be figures in a tableau against majestic organ pipes in Orchestra Hall.

Above: Four of 22 honorary fellowships conferred at annucl convocation went to: (l. to r.) the Rev. Jchn S. Flanagan, S.J., executive director, Catholic Hospital Association, St. Louis; Maurice J. Norby, AHA deputy director, Chicago; Kenneth Williamson, director, AHA's Washington service bureau; and Richard M. Jones, director, Blue Cross Commission, Chicago.

At right: Also recipients of honorary fellowships were: (standing, l. to r.) F. Burns Roth, M.D., deputy minister, Department of Public Health, Regina, Sask., Canada; Sir Arthur Stephenson, architect, Melbourne, Australia; and Edward L. Turner, M.D., secretary, Council on Medical Education and Hospitals, American Medical Association, Chicago. Seated, l. to r.: Ella Best, R.N., retired executive secretary, American Nurses' Association, New York City; and Paul R. Hawley, M.D., director, American College of Surgeons, Chicago.

• "For long-time success, the best administrators are those who have socially justifiable purposes and who enlist loyalty to them by provocatively creative appeals to the groups involved in getting the purposes realized," Ordway Tead, vice-president, Harper and Brothers, said in the Arthur C. Bachmeyer memorial address before the American College of Hospital Administrators.

He mentioned seven attributes needed to meet administrative situations: purposiveness, leadership, communication, co-ordination, collective dealing, creativity, and community concerns (see quotation on page 25).

New ACHA president-elect is Ray E. Brown, superintendent, University of Chicago Clinics, and a past president of the AHA. Anthony W. Eckert, director, Perth Amboy (N.J.) General Hospital, took office as president, succeeding Frank S. Groner, administrator, Baptist Memorial Hospital, Memphis, Tenn.

Anticipate Joint Commission Will Require Infection Committees

Commission Head Calls Staph Peril Greater than Any Can Imagine

Changes anticipated in the standards of the Joint Commission on Accreditation of Hospitals are:

1. Hospitals will be required to set up infection control committees. Such committees have been recommended before, but not very many hospitals have one.

Nursing services should be utilized to report infections. Many hospitals have had infections which have not been recorded because the methods of reporting within the hospital are poor.

2. More stress will be put on medical staff organization—attaining quality care through documentation provided by good medical records.

3. Criteria of care for departments of internal medicine will probably be instituted through medical audits.

4. The proposed amendment which would allow "clean" surgical cases to be housed in the obstetrical unit will not be approved. With infection rampant in hospitals and the community, this is no time to lower the bars.

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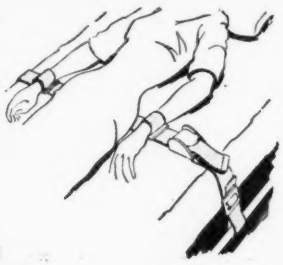

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The staphylococcus peril is fifteen times greater than any of you can imagine. The answer will not be found in a new, all-powerful antibiotic. These infections are the result of poor environmental hygiene. Ultraviolet light and detergents cannot replace proper technics.

Is the Joint Commission getting tougher? My answer is "no" with qualifications. When a hospital has procrastinated in correcting a condition, something must be done. There has to be a time when quality cannot be ignored, and a limit must be set.

Responsibility for quality care, including infection control, must be shared by all. Doctors often need more "missionary work" on controlling infections than hospital people do. The trustees of an institution may delegate their responsibility for quality of care, but they cannot relegate it. In the final analysis, trustees will be held responsible.

If the administrator is to control hospital procedures, the open door policy must work both ways. Employees must be able to get in to see him, but he must also go out to communicate with them.

Every administrator should frequently inspect his hospital from basement to top floor, investigating areas of possible contamination. He should examine technics; restudy traffic patterns; make sure personnel are properly trained; see that those in responsible positions are backed up with enough authority; be sure each department knows just what its responsibility is; find out whether the procedures and equipment being used are the best for that situation and are doing the job they are supposed to be doing.

Quality is never measurable in exact quantity—it's a question of circumstances and judgment and common sense.—*Kenneth B. Babcock, M.D.*, director, Joint Commission on Accreditation of Hospitals, Chicago.

Dr. Nelson Named President-Elect

Russell A. Nelson, M.D., director, the Johns Hopkins Hospital, Baltimore, and chairman, Council on Professional Practice, was named AHA president-elect at the final session of the House of Delegates.

Ray M. Amberg, director, University of Minnesota Hospitals, Minneapolis, was installed as president, succeeding Tol Terrell, administrator, Shannon West Texas Memorial Hospital, San Angelo, Tex.

John N. Hatfield, director, Passavant Memorial Hospital, Chicago, and 1958 recipient of the AHA Distinguished Service Award, was re-elected treasurer.

Elected trustees for three-year terms were: D. R. Easton, M.D., medical superintendent, Royal Alexandra Hospital, Edmonton, Alta., Canada; Frank S. Groner, administrator, Baptist Memorial Hospital, Memphis, Tenn.; and Clarence E. Wonnacott, administrator, Dr. William H. Groves, Latter-Day Saints Hospital, Salt Lake City, Utah.

Total registration at the meeting was 11,130—7,461 general registrants and 3,669 exhibitors. The 1959 convention will be held August 24-27, at the Coliseum, New York City.

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Progress Report on a Reopened Hospital School of Nursing

By Warren R. Von Ehren*

In the September 1956, issue of HOSPITAL TOPICS, *pages 23-26, Mr. Von Ehren described "Why We Reopened Our Nursing School." In this article, adapted from a talk he gave at the recent Tri-State Hospital Assembly, Mr. Von Ehren discusses the first three years of the school's operation.*

Just three years ago, our hospital reactivated its three-year diploma school of nursing which had been closed in 1950 because of lack of a qualified faculty and adequate student housing. This article reports our experience with this effort and our progress to date.

We originally reactivated the school because we, like hospitals across the country, were faced with the continual shortage of a sufficient number of adequately trained personnel to staff the hospital. It has been our philosophy that every hospital, regardless of its size, must train many of its personnel if it is to have a staff adequate to render a high level of patient care. Most hospitals have done this for a number of years, primarily through the medium of on-the-job training programs. Because of our peculiar geographic situation, in a primarily rural area, and because there are no other schools of nursing in this immediate vicinity, we decided to reactivate our own school to provide trained personnel.

Our new school has been in operation three years this September; we now have three full classes in training. At the time we decided to reactivate the school, we carefully considered the problems we would face and determined that they would fall into five general areas; we have since found that most of our problems have indeed fallen into one of these general areas and I will discuss each area in some detail to indicate the solutions we arrived at to resolve the problems.

The five original areas were:

1. Recruitment of faculty.
2. Financing of the school.
3. Provision of adequate housing for students.
4. Recruitment of students.
5. Development of a sound educational program.

In addition to these fives areas we probably should consider the following two facets of the program:

6. The importance of the hospital diploma school of nursing in the over-all program of the education of professional nurses.
7. Benefits the hospital derives from operating a school of nursing.

We have solved, at least partially, the problems in these areas in the following manner.

1. Recruitment of faculty. We now have a full complement of instructors and assistant instructors and except for the usual turnover found in any school of nursing staff, our faculty has been fairly stable. In addition to having a director of nursing service

(*Continued on next page*)

* Administrator, Bellin Memorial Hospital, Green Bay, Wis.

The chorus is one of the most popular extracurricular activities among the student nurses at the Bellin Hospital school. Here chorus members, students of the classes of 1958 and 1959, pose for portrait after a concert. They are (left to right): First row: M. Konstanski, C. Eckblad, J. Dix, B. Richardson, B. Olsen, J. Nelson, J. Lloyd, N. Overdier, N. Cheli; Second row: E. Kinyon, S. Bair, B. Andrews, R. Lewandowski, C. Moes, C. Gehling, J. Teske, C. Zeitler, A. Krause, M. Pennington, J. Koehler, P. Robb, L. Brandt, M. Larsen, G. Radloff, B. Robeck, M. Dettmann; Third row: V. Querns, D. Marineau, S. Coffey, M. Gibbons, J. Dvorak, L. Bierbrauer, E. Reimer, E. Naeser, J. Plowman, J. G. Scheller, J. Miller, M. Knuth, D. Reinke, G. Myer, M. Sandberg, A. Motiff, B. Petersen, L. Lewke; Fourth row: D. Penn, J. Larsen, C. Wright, C. Molus, J. Steffeck.

Students board bus to go to classes at Green Bay Vocational School and University of Wisconsin Extension Center. Left to right are: B. Ochs, D. Penn, J. Koehler, J. Strasser, L. Bierbrauer, and J. Nelson.

and nursing education—a nurse who holds a master's degree in education—we have a full-time assistant director for nursing education, who also holds a master's degree; a nursing arts instructor; an assistant nursing arts instructor; an instructor in medical nursing; an instructor in surgical nursing; and an instructor in obstetrical nursing. All of the instructors have bachelor's degrees with the exception of the obstetrical nursing instructor who is currently working toward a degree.

Our instructors, head nurses, assistant head nurses, and other personnel of the nursing staff who are engaged in the teaching program, attend, on a continuing basis, St. Norbert's College, West DePere, Wis., and the Green Bay Extension Center of the University of Wisconsin. At these schools special courses have been arranged in subjects needed to qualify personnel for teaching responsibilities. The hospital's policy is to allow these people a maximum of three hours' duty time with pay to attend these classes; however, the hospital does not pay any of their expenses such as tuition or books.

A dietitian serves on the faculty as a part-time instructor, teaching the courses in nutrition and cookery, and diet therapy. The laboratory facilities of the Green Bay Vocational School are used for this purpose.

Instructors in the preclinical subjects, such as chemistry, microbiology, and sociology, are not provided as a part of the school of nursing faculty since these courses are taught at the Green Bay Extension Center of the University of Wisconsin by regular, full-time University faculty members. This also eliminates the necessity of our providing laboratory facilities in the school for these courses.

2. Financing the School. Education of student nurses is expensive and the problem of adequate financial support is of paramount importance. We have made some progress in resolving this problem, although much remains to be done. At the present time, financial support of the school comes from the following sources:

a. Student fees and student services.

b. Donated services, including such items as lectures by members of the medical staff, and a student health program conducted by the medical staff.

c. Fees from patient services.

d. The patrons program.

e. The Wisconsin conference of the Methodist church

The first three items are self-explanatory. However, the last two are somewhat unusual.

About two years ago, we set up a patrons program in an effort to solicit contributions to support the yearly operating budget of the school from individuals and businesses in the area served by the hospital and the school.

Basically, the program seeks to secure a minimum donation of $100 per year per person or business. We have been pleasantly surprised by the enthusiastic support the program has received. In spite of the short time it has been in operation, the program is now bringing contributions totaling $10,000 per year. Our goal is to have 500 patrons, which would realize an income of $50,000 per year. This would go a long way toward meeting the costs of operating the school.

We firmly believe that the education of nurses is a community-wide responsibility, just as public education is, and that the community as a whole should be asked to bear a fair share of the costs. We do not believe that the patient should be taxed to support the school, although the patient can and should be expected to bear a portion of the cost since he benefits directly from the program.

Since our hospital is an institution of the Methodist church, we asked the church to help with the financial support of the school. In the current quadriennium of the Wisconsin conference of the church, our school has been designated as an institution of higher learning and as such will receive a certain proportion of the conference educational budget. We anticipate that this will mean a grant of $10,000 per year for the operating budget.

We have every reason to believe that the church will continue to support the school even after this quadriennium is completed in 1960. We believe that the support of our school by the church as an institution of higher learning is unique since we know of no other schools receiving such support.

The cost of operating the school for the current fiscal year is $117,108.88. Income received from the sources mentioned amounts to $81,041.67, making our net cost of operating the school $36,067.21. With a total enrollment of 60 students, this makes our operating cost about $600 per student. Not included in this cost is depreciation of the dormitory building and equipment and certain services provided by the hospital such as the maintenance provided by our engineering department, and upkeep of buildings and grounds.

3. Provision of adequate housing for students. Prior to the reopening of our school, we constructed a new dormitory to house student nurses. The building provides quarters for 78 students and also includes classroom space and recreational areas. The total cost of land, building, and equipment was $350,000. The funds came from a Hill-Burton grant and a community campaign which raised the balance.

The new dormitory facilities provide modern and complete quarters for the students and will continue to serve our needs adequately for some time in the future. Sufficient land and space is available to provide additional facilities, should the size of the school be increased.

4. Recruitment of students. Our recruitment program is centered around two areas of endeavor:

a. Contacts with prospective students made through career days at high schools in the area, and through referrals from teachers, vocational counselors, clergymen, and friends. A member of our faculty, on invitation from high schools in the area, talks at vocational or career day programs on nursing as a career in general and on the program at our school in particular.

Last fall we inaugurated a new program. Twice each month we invite junior and senior students from high schools in the area to spend a weekend at the dormitory and the hospital to learn something of our operation.

The students arrive at the dormitory at 5 p.m. on Friday and leave at the same time on Saturday. In the intervening 24 hours, they spend a night in the dormitory, attend classes with the nursing students, make ward rounds, take a tour of the hospital and the dormitory, attend an informal coke party on Friday evening and eat their meals in the hospital cafeteria. The high school students pay no charge for this weekend, although they must pay their own transportation to the hospital and return home.

Capping ceremonies are highlight of training. Above, newly capped group of Bellin students form candle procession as families and friends watch.

This program has proved to be very popular. About 10 prospective students attend each session. Thus far, about 150 girls have participated in these sessions and, from this group, we have received about 60 applications. We feel this facet of our recruitment program has paid us excellent dividends for the time, effort, and funds expended.

Other recruitment efforts include sending out periodic mailings to vocational counselors, clergymen, and others who might refer interested applicants to us. Last fall we also held an orientation program to which we invited 35 high school vocational and guidance counselors. They spent an evening at the dormitory and the hospital learning about the program and touring our facilities. The hospital gave them a complimentary dinner following which student nurses spoke briefly on various aspects of the educational program including entrance requirements, fees, and scholarships available. This also was an effective program.

Another important factor in the recruitment of students has been a number of scholarships which we have available. These provide funds for about 25 percent of each incoming class for full or partial aid, dependent on need.

Thus far we have found recruitment not too difficult a problem. With the new programs we have developed this past year, we feel that we will always have sufficient applicants to meet our needs. We have found that the quality of applicants is high.

5. Development of a sound educational program. From the outset we planned our educational program to meet the requirements for approval by the State Board of Nursing and also for accreditation by the National League for Nursing. We have received full approval from the State Board and provisional ac-

(*Continued on next page*)

creditation from the National League. We will not be able to qualify for permanent accreditation by the latter group until our first class has been graduated and the results of the State Board examinations are known. However, we have every confidence that permanent accreditation will be achieved since our entire program has been planned, organized, and oriented to that end.

To assure continual sound development of our educational program, we have appointed an advisory committe on nursing education which is composed of representatives from the faculty, the board of directors, the hospital administration, and from the community at large, including people in the fields of general education, public health, and medicine. This committee meets regularly to review the program and make recommendations for its continual improvement. The faculty also holds regular meetings to review the program on a continuing basis and make sure that it operates at a high level.

The co-operation of the Green Bay Extension Center of the University of Wisconsin in teaching the preclinical nursing subjects has done much to strengthen the program.

6. The importance of the hospital diploma school of nursing in the over-all program of the education of professional nurses. There is much discussion concerning who should educate professional nurses. Some argue that this should be the function of regular organized educational institutions, such as junior colleges, senior colleges, and universities. Those on the other side of the fence argue that this education can best be given by the hospital school of nursing, especialy the basic professional program to educate bedside nurses.

Perhaps one or the other of these viewpoints is right, or perhaps neither is wholly correct and a combination of the two is the answer. However, no matter how we feel about educational courses for professional nurses, I think we will all agree that clinical training, at least, must be given in the hospital. For this reason, it seems to me that whatever program is developed must include hospital orientation for the clinical phases of the program; thus the hospital assumes a vital role in nurse education.

Every hospital, regardless of its size, must provide educational orientation, and it seems logical that this orientation should be expanded to include the education of professional nurses. There is no question that our greatest need is for adequately trained general-duty nurses, although I realize that the education of administrative and teaching personnel is also impor-

(*Continued on page 38*)

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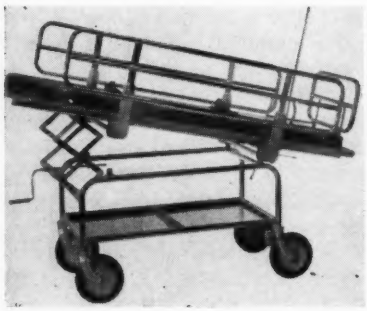

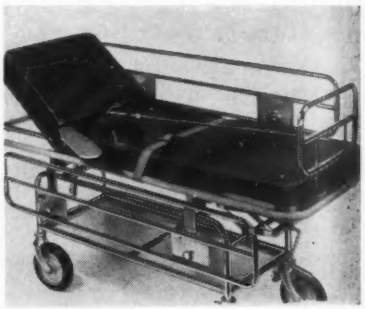

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(*Continued from page 36*)

tant. It seems to me that the hospital school can do the job of training general-duty nurses well.

The hospital can provide the basic foundation on which further education can be built and, in fact, is in a particularly advantageous position to do a good job in this area. Certainly the colleges and universities cannot educate enough professional nurses to meet all the needs for personnel to assume bedside nursing care responsibilities. Hence, in my opinion, the hospital school, in some form, is essential.

In the final analysis, it seems to me that someone must train professional nurses for bedside care and if the hospitals do not do this, who will?

7. In reviewing our program we have discovered the following benefits accruing to the hospital from the operation of the school.

a. Relations with all of our many publics—the community, the medical staff, the patients, our own staff—have improved considerably.

b. Having a school has helped in the recruitment of our professional staff of nurses, technicians, and others. We have found it somewhat easier to attract personnel on the strength of having an educational program since many professional people like to be associated with a hospital that is educationally oriented. Further, having our own school does assure us, to some degree at least, of having an adequate staff of graduate nurses.

Since a number of the students have stayed on after graduation, we have had a continual supply of nurses to replace those lost in the normal turnover.

c. Relations between the hospital and its medical staff have improved because the doctors appreciate the fact that an educational program raises the level of patient care and keeps the rest of the hospital personnel "on their toes." Nearly all of the doctors participate in the teaching program.

d. Having a school has improved patient care. In planning our curriculum, we have had to take a long and continuing look at the type of patient care being given to revise it in the light of the experience we must provide for students. Even the relatively short period of time students spend on the nursing stations during their first year has had a salutory effect on raising the level of patient care. Of course, the time spent increases during the students' last two years. The program has made our staff more aware of its responsibilities both from the standpoint of patient care and from that of the teaching of students.

e. Having a school has also given the hospital a certain amount of prestige in the area it serves and has been an important factor in the attraction of patients. Although this is a rather indirect benefit, it is, nevertheless, of importance.

This article has highlighted some of the problems and accomplishments we found in reopening our school of nursing. We are all agreed that if we were faced again with the decision of whether or not to reopen the school, we would make the same decision.

HOSPITAL *Topics*

Goes Calling

. . . on Fred G. Welsh
Administrator
Brookside Hospital
San Pablo, Calif.

Administrator Welsh at hospital's main entrance.

• "Most important—our patient" is the motto of Brookside Hospital, San Pablo, Calif. That these are really "words to live by" for the Brookside staff is apparent to anyone spending a few hours in the hospital.

The esprit de corps in a hospital, it has often been said, must stem from the top—from the administrator. It does at Brookside. Administrator Fred G. Welsh, a former "Flying Tiger," American Overseas Airlines pilot, and teacher before he decided to enter a school of hospital administration,* is full of ideas on how to make the hospital a better place for both patients and employees.

One idea recently put into effect can be traced to his commercial airline background. Why not, he reasoned, greet patients and staff every morning with an announcement over the paging system, much as airline flight personnel welcome their passengers soon after takeoff?

The switchboard operator, at 8 a.m., now says, "Good morning! This is Brookside Hospital." She then gives the time and temperature, and perhaps adds a sentence or two about some phase of the hospital's operation, in somewhat the same way the pilot gives his passengers a few facts about the countryside over which they are flying.

Perhaps Mr. Welsh's teaching experience may explain his interest in what is still an experiment in nursing education—the two-year junior college program. The hospital recently became affiliated with the Contra Costa Junior College (west campus, San Pablo) to provide clinical experience for students in the associate degree program at that school.

"Why shouldn't nurses get more of their education in the classroom, as medical students do in their undergraduate experience?" the administrator asked.

A nice personal touch is the celebration of employees' birthdays—not individually, but at a party once a month for everyone with a birthday during the month. Another idea put into effect July 1, under union agreements, gives every employee a paid holiday on his birthday. Such an arrangement grants everyone another holiday without the accompanying disadvantage of having all employees off on the same day.

Brookside, which opened three years ago, admitted its 30,000th patient this summer. It has grown from 165 beds to 198 to the present 248 (with 24 bassinets). Most recent addition was the pediatrics floor of 50 beds, which became the hospital's seventh floor.

Situated in a growing industrial and residential community, across the bay from San Francisco, the hospital stands out sharply from its surroundings (see aerial photograph), because of its attractive design, its height (most structures in the area have one story), and its beautifully landscaped grounds.

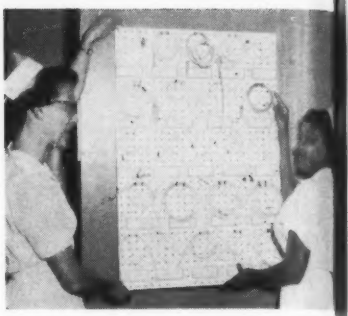
(Continued on next page)

*University of California, School of Public Health course in Hospital Administration. He received an M.P.H. degree.

Aerial photograph, showing how building dominates the surrounding area.

The administrator at his desk in handsome, wood-paneled office, which is large enough to use for board conferences. Folding doors which originally divided the area into an office and a conference room have been removed.

Center: Mrs. Bertha Hoffmann, emergency department admitting clerk, receives information on an incoming case via two-way radio from the ambulance.



Right: In central supply department, Mrs. Lillian Lashbrook (l.) and Matlyne Eubanks display board on which are mounted samples of all kinds of tubing available in the department. Each type is clearly labeled. Board is a teaching aid for new employees, and also enables anyone from outside the department to see at a glance what tubing is in stock.

TOPICS GOES CALLING continued

The presence of industrial plants in the hospital's service area has probably been an important factor in the rapid growth of the hospital's busy emergency department, which now treats 1,100 cases a month. Industrial accidents account for a fair percentage of the cases, although automobile accidents bring in the greatest number. Children who have been poisoned are treated in the poison control center in one part of the emergency suite.

A great aid to efficient operation of the department is the two-way radio service between the department and the private ambulance company which services the hospital. The hospital is notified in advance of the patient's arrival, so that appropriate preparations may be made.

The overtaxed service has two rooms with a nursing station between. It is planned to add three treatment rooms, with one room for minor surgery. If a patient requires major surgery, the operating room is on the same floor (the first) as the emergency suite.

The department includes a "quiet room" for breaking bad news if necessary.

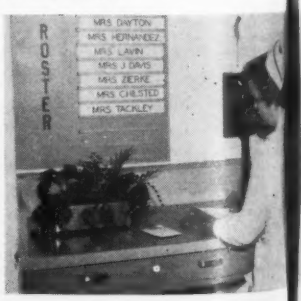
Separate business office facilities for emergency patients and outpatients are found in the emergency suite. They were set up for the convenience of the patients, so that they would not have to go down the long hall to the main business office.

There are one nurse and one administrative clerk for each shift, and three employees (two full-time and one part-time) to handle outpatient and emergency work. Twenty doctors are assigned to the emergency service, and are guaranteed a stipend. The service is a private one, and the patient is charged for treatment rendered, unless he is unable to pay.

Assistant administrator G. William Wood, M.P.H., University of California, who has the emergency department as one of his responsibilities, believes the service has attracted doctors to the community. They have been able to get on the service, have become interested in the hospital, and have brought their patients there. Before Brookside was opened, emergency cases had to be taken to what was really a first-aid station, and then transferred to a hospital.

(Continued on page 42)

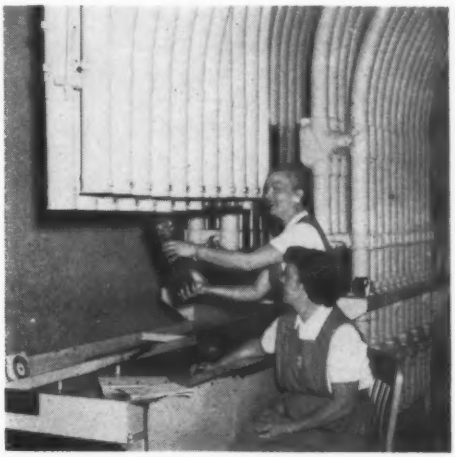
Below, left: Long, open nursing station on the sixth (orthopedic) floor was specially designed to make it easier for several persons to work there at the same time. Patients' charts are equally accessible from either side, because they fit into slots in center of table. Mrs. Jennie Binion, R.N. (l.), and Thelma Wood, R.N., are shown at desk. At right: Mrs. Dorothy Bradley, R.N., at charge nurse's desk behind nursing station. Roster, listing names of nurses on duty, was made in carpentry shop.



This, in the administrator's own words, is the "Welsh rabbitt"—shown with Mrs. Esther Christoffersen, R.N., head nurse, obstetrics, at 1958 Easter party, an annual event for all children born in Brookside Hospital.

Usually Easter party features an egg hunt on the large lawn, but weather made it necessary to move festivities inside this year. The attendance didn't suffer, though—750 attended. Little "rabbit" is Jill Anderson.

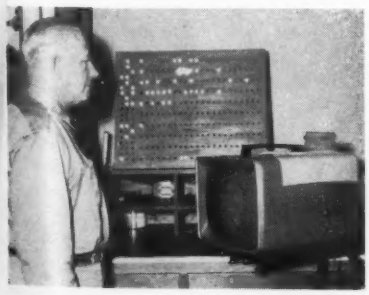
The hospital has a "mothers' club" for mothers of babies born in the hospital. These mothers and infants are shown at the club's quarterly tea.



Above: One responsibility of hospital's active service league is staffing the pneumatic tube room, as Mrs. Adelyn Edgar (l.) and Mrs. Dolores Cowan are doing here. League members are called "Flamingos."

Donald Miller, M.D., dictates information for a patient's medical record, in booth conveniently situated between medical record department (at left) and doctors' lounge and medical library (at right). Another device to make it easier for medical staff members to keep their records up to date is a special plug on the switchboard, for use when a physician calls in from outside the hospital to dictate a record.

Below: Birthday party is held every month for all employees with birthdays during the month. In addition, notice of each birthday is posted on the bulletin board in the cafeteria. Notice is in form of paper birthday cake which bears name of employee and birth date.



Hospital owns TV sets which are available for rental by patients. A. A. Logefeil, chief of plant operations, is shown here with board which tells him in what rooms sets are being used.

A nursing supervisor designed the specially built, cut-out table at which little Sean Carroll is eating his lunch, and table was built in the carpentry shop. Child may be fastened securely in place for eating or playing. Table is in the infant unit on pediatrics floor. Sean's companion is Mrs. Audrey Brown, a volunteer.

Mingo puppet is given to every child admitted to the hospital.

Small patient waits eagerly for lunch being dished out for her by Mrs. Vernon Nuss. Hot-and-cold food cart keeps food in containers, at proper temperatures, until toddlers are ready to eat. Cart was adopted for use in infant unit because of tiny tots' dawdling in eating.

TOPICS GOES CALLING continued

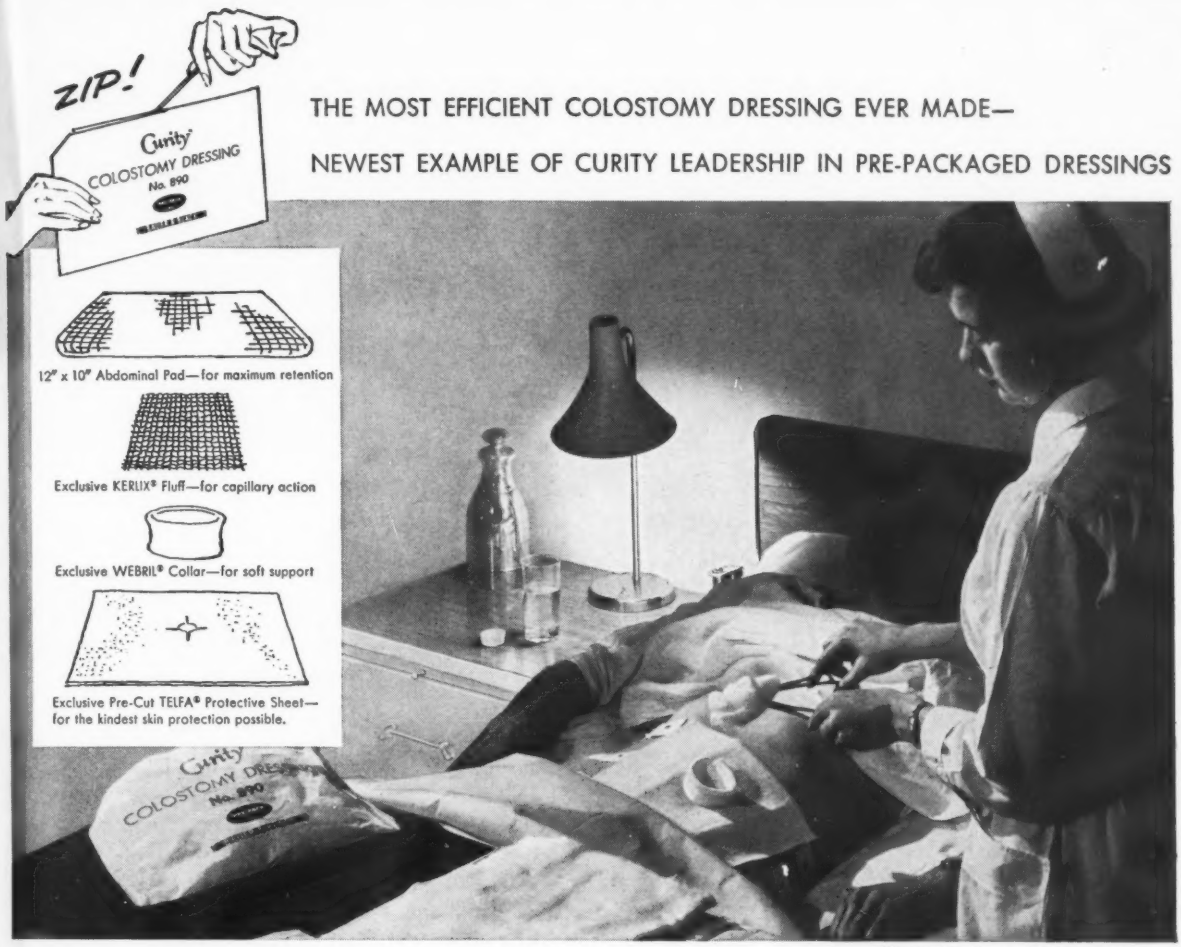
Brookside Hospital has no great staffing problems, so far as nurses are concerned. For one thing, the hospital is a pleasant place to work—for nurses as well as for other employees. Moreover, pay is good (statistics recently released by the American Nurses' Association show that nurses in the San Francisco-Oakland area are among the highest paid in the country).

The hospital has 409 employees, of whom about 30 are part-time. Supplementing the work of the paid staff are approximately 150 active volunteers, members of the hospital's service league. They work in the pneumatic tube room, arrange and deliver flowers, take the library cart and cosmetic cart around to patients, deliver newspapers, staff the gift shop, escort patients from the admitting office to nursing stations, sew "Mingo" puppets, read to patients and write letters for them, help feed child patients, and supervise the game room. Proceeds from the gift shop make gifts of equipment available to the hospital. The administrator and other hospital personnel are high in their praise of the service rendered by this service league.

Artist Wolo von Trutzschler paints wall mural for the pediatrics floor. He draws his animal characters in chalk, then fills them in with the finest oil paints in vivid colors (see story about Wolo on page 98).

Mrs. Ann Van Winkle, play and speech therapist, with children in playroom on pediatrics floor. Table and chairs were built in hospital carpentry shop. Ambulatory patients may eat in the playrooms. In the morning and afternoon, children come in to watch TV, read, color, or play with toys. A child confined to his crib may be wheeled in, too, so that he won't feel left out.

Nurses like counter-height, stainless steel tub in infant unit because it makes giving a bath easier. It is big enough and deep enough to enable toddlers to splash around a little. Mrs. McDougal, L.V.N., gives Sean Carroll a bath.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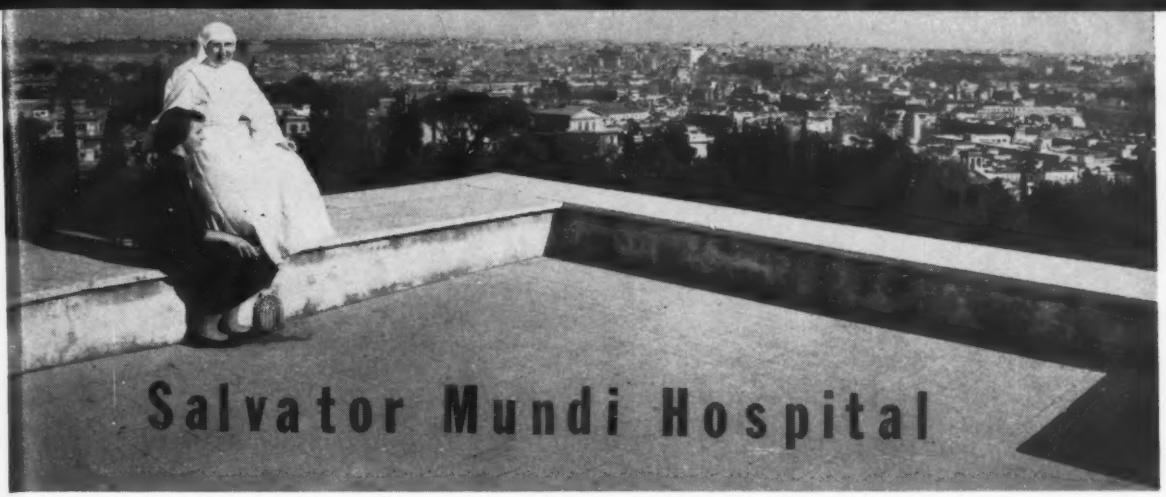


Salvator Mundi Hospital

By John G. Steinle

During his recent extensive study of hospitals, medical schools, and medical care programs in the Mid-East and Europe, TOPICS' *consulting editor, John Steinle, found Rome's Salvator Mundi Hospital one of the most interesting and unusual places he visited. In this article, he tells the Salvator Mundi story.*

• In Rome, during my visit to the Vatican, when my interest in hospitals was made known, I was immediately asked, "Have you visited Salvator Mundi?" This same question must have been put to me at least 25 times that day, and I decided I must visit this medical showplace. The next day, in company with an interpreter and an Italian driver, I started out.

Our car slowly wound its way up one of Rome's highest hills, the Janiculum. At the summit, above the old wall of Rome and nestled against a background of trees, was a magnificent, streamlined, light brick and travertine marble building.

We parked in an ample lot, neatly hidden among the trees so that it would not detract from the monumental facade of the building. Marching through the magnificent entrance, we entered the marble lobby and found it just as impressive as the exterior of the building.

At the reception desk, which was made of a green marble, the interpreter turned to the Sister receptionist to identify me. However, before he could say a word, she smiled warmly and said, in perfect English, "Oh, you must want to see Sister Monica, our administratrix."

"Are you from the United States?" I asked.

"No," she said, "I have never been there." Then she added, as though this were the perfect explanation, "This is our English-speaking day."

Later I learned that Salvator Mundi is an international hospital in every sense. English, German, and Italian are the official languages of the hospital—on alternating days. However, a patient always can find a Sister or an employee with whom he can communicate, regardless of his language or place of origin.

One of the most exciting features of Salvator Mundi is the story of its origin, planning, and construction. The person responsible for it is Mother M. Olympia, appointed fourth Mother General of the Sisters of the Divine Saviour in 1947. She had a wide background in hospital work before becoming Mother General of this international order, which has almost 2,000 Sisters in five continents. Previously Mother Olympia had been administratrix of hospitals in her home state of Wisconsin and in South Dakota.

One of the major problems confronting Mother Olympia when she became Mother General was developing a program to train Sisters to operate hospitals all over the world in accordance with standard procedures and at an optimum level of quality.

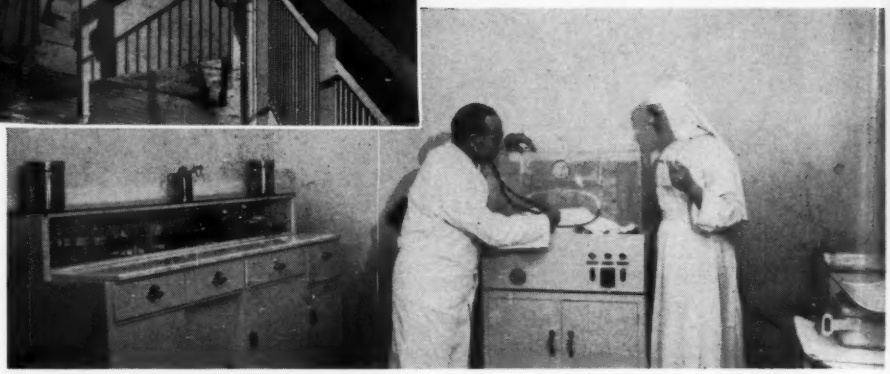
The best way to achieve this goal, she decided, was to establish a hospital, a training center which would be part of the novitiate "Villa Salvator Mundi."

The first step was securing finances for the project. This was achieved by obtaining a loan from a bank in Milwaukee, Wis.

(Continued on next page)

Above: Salvator Mundi stands atop one of the highest hills of Rome. Sister Monica, American-born administratrix, sits on the hospital's rooftop sun deck with visitor, viewing the city of Rome in the background.
Right: The international nursing staff includes graduate nurses from the U.S., Ireland, England, Belgium, Holland, Switzerland, Germany, Austria, Poland, Hungary, Australia, China, and Italy. Though the Sisters hold diplomas from their own respective countries, at Salvator Mundi they learn, and practice, standard nursing procedures which are followed by their order throughout the world.

Above: Each room opens on a balcony so that patients can get the maximum benefit from Italy's famous sun. Room rates range from $5 to $10 per day, with luxury suites available at $15 per day.



Right: The premature nursery is well-designed and efficient, its work area extremely well-equipped.

SALVATOR MUNDI continued

Mother Olympia planned almost all of the hospital herself. The artisans of Rome have probably still not completely recovered from the shock of having a nun constantly supervising their work and urging them on to a greater daily output.

The result of this planning and work was Salvator Mundi—translated "Saviour of the World"—a 130-bed general hospital.

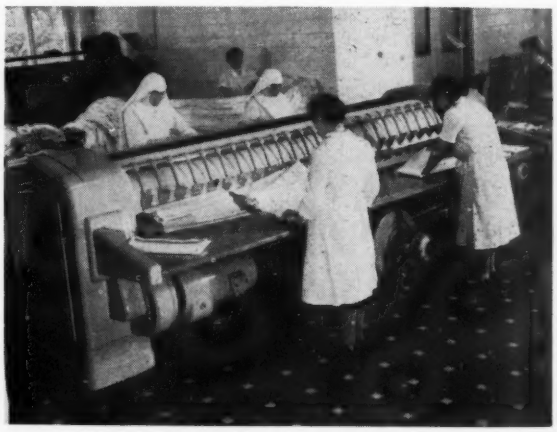
The hospital is shaped as a rough "S." Touring the institution with Sister Monica, I found that the first floor included all central services, the diagnostic and treatment facilities such as x-ray, laboratory, and surgical suite, and the outpatient department.

There is no central sterile supply. Sister Monica explained that each area has a different make of autoclave to provide the Sisters with experience in using all types of sterilizers. Thus, whether a nun is sent to Ceylon, Tanganyika, or Milwaukee, she will know how to operate the equipment, be it German, Swiss, British, or American.

The large Italian stove in the kitchen can be operated with wood, coal, gas, or electricity. This not only affords experience with various energy sources, but also assures continual operation—in an emergency, neighboring trees can supply the necessary fuel.

Below: In this international kitchen, each Sister contributes her country's specialties to the scientific diets. The large stove in the background can run on wood, coal, gas, or electricity.

Patients in this teaching institution receive the best in everything and always, the patient comes first. A light panel in the administrator's office permits monitoring of all calls from patients for service. Any light left unanswered for more than a few seconds is noted by the administratrix or one of her assistants.



Above: The modern laundry has complete, modern equipment, is also light and airy, providing a pleasant working area.

All rooms have silent switches, which Mother Olympia, herself, designed. The cashier's cage and the interviewing rooms, in which financial arrangements are made, are completely isolated from the lobby. There is a small special room from which children can look down into the nursery to see the new baby brother or sister.

Perhaps most important is the security and protection offered the hospital's many famous patients. Ingrid Bergman's twins and Gina Lollobrigida's baby were born at Salvator Mundi.

The medical staff is composed of the outstanding physicians in the Rome area. In Italy, the patient

Above: The chapel is on the third floor. Patients may also be visited at any time by clergymen of their choice.

Right: The hospital has a "family observation room" next to the nursery. At the top of the picture, a youngster is seeing his baby brother for the first time.

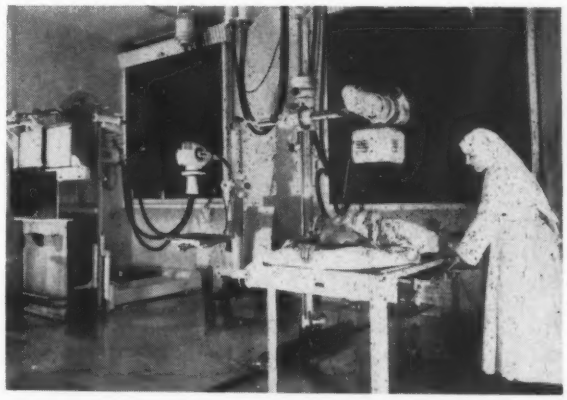
generally comes to the hospital, which assigns the physician. Obviously, this assignment of physicians to patients presents many difficulties. Since most private hospitals are named after the principal physician of the institution, it is not at all unusual to have a prospective patient ask to meet Dr. Salvator Mundi.

Most physicians are employed by the government. However, they are permitted to maintain a relationship with private clinics and hospitals, if they wish. There are no interns or residents in Italy. The functions ordinarily associated with interns and residents in the United States are performed by "guardians," physicians in private practice who work part-time for the hospital.

Medical records ordinarily are not maintained with the same thoroughness in Italy as in the United States. However, the American standard is required at Salvator Mundi. Maintenance of this standard has necessitated a course in medical records for the physicians, the training of record librarians in the United States, and an almost complete turnover in the medical staff since 1951.

Medical records training is far from being the only unusual problem. For instance, the international nature of the hospital causes many difficulties with food and customs. At present 15 nationalities are represented by the nuns at Salvator Mundi. The director of diagnostic services is Sister Benigna, a medical doctor from Germany who is licensed to practice in Italy. Before entering the Congregation of the Sisters of the Divine Saviour, she worked with the American army after World War II.

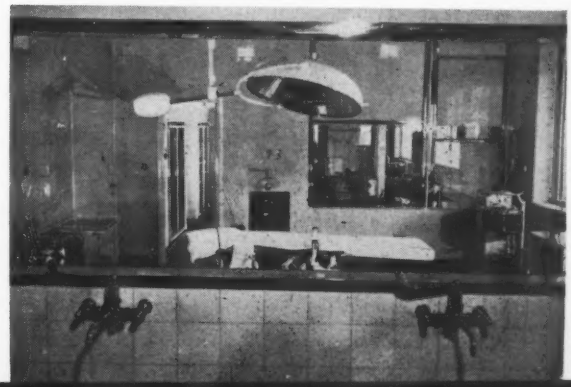
However, the many diverse elements blend well at Salvator Mundi. This gorgeous monument to the Saviour of the World is also a highly functional and efficient hospital.



Above: The modern x-ray department includes the latest diagnostic and treatment equipment. The room has marble floors.

Left: The medical record room is American in every respect except language. The records, of course, are recorded in Italian.

Below: The operating suite, with equipment from many countries, was the first outside the Americas to be equipped with carbon black conductive floors.



Hospital Purchasing and Stores

Another in a series on hospital organization, based on lectures given at meetings of the Association of Western Hospitals and allied state groups

By John H. Gorby*

I. Purchasing

• Hospital purchasing is a specialized function, and a productive one. In most hospitals, one dollar of three is expended for purchase of equipment, supplies, and services. The purchasing and stores activity provides service to all other departments of the hospital.

Economies in purchasing and storekeeping constitute a fertile area for reducing general hospital expenditures. The integration of purchase planning and budget formulation, together with the centralization of buying by trained personnel, will provide substantial savings in many hospitals. The reduction of purchasing costs by a mere one to three percent, a solidly practical possibility which has been achieved in many institutions, has afforded economies ranging from $30,000 to $100,000 annually.

PREPARING THE REQUISITION

The requisition phase of purchasing includes the proper identification of the item to be purchased and the preparation of a requisition for the purchasing agent. It is a point at which problems often are encountered. A sample purchase requisition form is shown in Figure 1 on page 49.

A requisition should be used any time anything required for the operation of the hospital is taken out of the central storeroom. Every hospital should have one central point to which are brought all incoming shipments except those of fresh meat, milk, and other perishables for use in the kitchen.

The requisition for supplies from the central storeroom should originate in the department requiring the merchandise. In the case of the dietary department, a requisition should be issued whenever dry groceries are ordered.

No one other than the ultimate user can identify and describe exactly what is wanted. Thus, the user should include in the purchase requisition all information which might be needed to make the purchase. Particularly essential are the name and the specifications for the type of item desired. It is not enough to request "10 reams of bond paper" unless forms design has reached the point that these items are standardized. There are many different types of paper, each classified according to content, weight, and size. Delivery should not be requested "as soon as possible," because this request renders purchase planning inflexible and further, does not tell the actual date needed.

It is not unusual, and is quite acceptable, to combine in one form the standard requisition for purchases and that for obtaining items from stores. This allows the purchasing agent to decide whether the item should be purchased or should be issued from stores.

When the purchase requisition has been prepared, it should be conveyed to the purchasing agent by the most expeditious means. Many hospitals have found that cyclical requisitioning is the most effecient method. That is, specific departments forward requisitions on certain days of the week, and at no other time.

This system reduces the number of requisitions received by the purchasing office on any one day. The schedule can also be arranged so that deliveries, other than those for emergencies, are made to certain floors on certain days, thereby reducing the traffic on these floors on other days.

In general, the requisition should be pre-numbered and no less than three copies should be issued. The original should be sent to the storeroom or central supply, and the duplicate copy to the accounting department; the triplicate copy should remain in the possession of the department initiating the requisition.

Many hospitals require that the purchase requisition be approved by someone other than the department head, and often, by the administrator. Although requiring administrative review of these requisitions has the advantage of giving the administrator a detailed knowledge of hospital operations, approval of thousands of requisitions a year constitutes an excessive demand on the time of that busy individual. Assuming that requirements have been forecast, approved, and included in the budget, no additional approval should be needed for most items.

Also, requisitions are often forwarded through the business office, which pre-audits them for the availability of funds. This procedure should be unnecessary, unless the hospital is constantly in a low cash position. Also it delays the purchasing process. Department heads

(Continued on page 50)

*1816 Lincoln Ave., San Diego 3, Calif.

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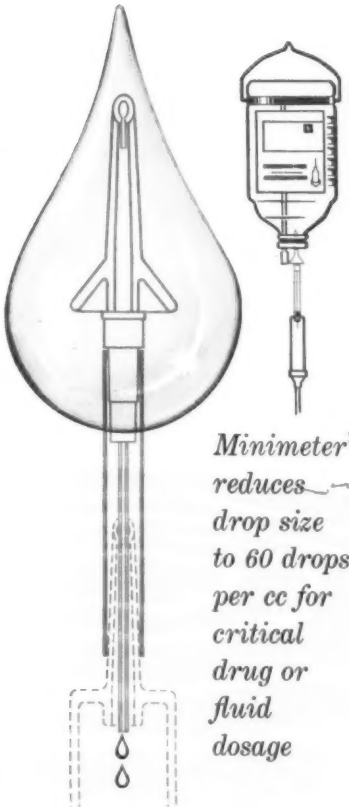

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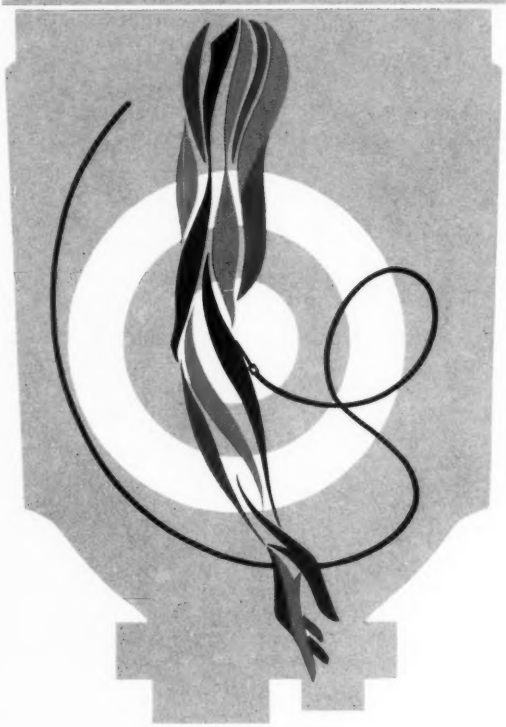

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Figure 1

PURCHASE REQUISITION

ROUTING	SPECIAL INSTRUCTIONS	CHARGE ACCOUNT NO.
1 2 3 PURCHASING		DELIVER TO

PURCHASE REQUISITION

			REQ. NO.	
SHIP TO			JOB ORDER/B.M.NO.	
DATE OF QUOTATION	DATE OF ORDER	PURCHASE ORDER NUMBER	REQ.DATE	DATE WANTED
VENDOR			APPROXIMATE VALUE	
ADDRESS			SUGGESTED VENDOR OR LAST ORDER NO.	

SHIPPING DATE	F.O.B.POINT	VIA	P'P'D.	COL.	TERMS

CODE	ITEM	QUANTITY/UNIT	DESCRIPTION	QUOTATION OR PURCHASE PRICE

For Purchasing Use Only	REQUESTED BY
1	APPROVED BY
2	PROCESSED BY
3	

(Continued from page 48)

should maintain copies of requisitions previously submitted, with probable prices affixed, so that they will be familiar with the status of their budgeted funds, making a pre-audit of the purchase requisition unnecessary.

If the requisitioner does not know the price of an item he requests, he may submit the requisition in two copies; then, one copy of the requisition can be priced and returned to him. However, if no unwarranted delays occur in the purchasing process, a copy of the purchase order can be provided to the requisitioner as soon as the order is issued. The file of purchase orders would serve as his record of expenditures made against the budget.

In addition, the accounting office should provide each department with monthly expenditure reports, so that the department head has available for future reference accurate records of expenditures and obligations.

PROCESSING THE REQUISITION

Processing the requisition requires first that it be checked against the inventory control records to determine if issues can be made from stores. It is during this phase that the decision of whether to make or to buy the item must be considered.

Larger hospitals often have highly developed maintenance and repair organizations which can make a number of the items needed in the hospital. Although it often seems that items can be made more inexpensively than they can be purchased, it is good policy to buy all desired items unless idle time is available in the maintenance organization. Further, such idle time might indicate overstaffing.

The purchasing agent must check each requisition carefully, because it is his or her authority to buy—to expend funds of the hospital. Particularly, it is necessary for the agent to determine that the statement of need is complete and accurate, that the requisition is signed by a person auhorized to obligate the hospital's monies for the purpose, that delivery dates are entered, and that the data on the requisition constitute adequate information to place an order with a vendor.

SELECTING THE VENDOR

Normally, the selection of vendor is not so troublesome in a hospital as it is in an industrial operation. Many policies affecting this phase of the operation must be decided by the hospital administration.

If the item can be procured locally, it may be necessary for the purchasing agent to place orders there for community relations reasons. Although this policy has the advantage of returning money to the sources from which, generally, it has been received, it also restricts the flexibility of the purchasing agent in obtaining price and delivery differentials by purchasing from out-of-town sources.

A controversy commonly exists over the matter of buying from established vendors at all times, as against buying on competitive bids to obtain the lowest price from a responsible vendor. Regardless of the practice favored, the hospital should, in any case, maintain a record of qualified vendors from whom purchases of particular types of items can be obtained, and of the unit costs for items from specific vendors. Requests for quotation of bids then can be furnished to qualified vendors when the item is required.

Some areas are fortunate in having a central purchasing service such as the Institutional Commodity Service of the Archdiocese of New York. The effectiveness of such a co-operative buying service is dependent on the extent to which it is used by participating hospitals.

When the same vendor always is used, he can be expected to supply requirements at all times, including periods when an item may be in short supply generally. Usually, however, such vendors eventually take advantage of this situation. It is considered better practice to obtain bids from all qualified vendors, and to place the order with the responsible vendor who can offer the item wanted, at the time needed, at the lowest price. Utilization of competitive bidding practices, in actual cases, has resulted in the reduction of prices by as much as 10 to 20 percent.

Before the order is placed, it is also necessary to determine how much should be procured—that is, what amount of the item constitutes an economic purchase. This decision is based largely upon the cost of the item, the administrative cost to place a purchase order, overhead charges for carrying items in stock, and the volume of the item used during a fixed period, usually a year.

Many people use detailed and complicated formulas to determine the most economical quantity to purchase. In most hospitals, however, this amount can be determined by reviewing rates of usage, costs for the item and delivery requirements, and by determining specific stock levels for inventory purposes in terms of supply for a specific period of time, such as three or six months.

There are a number of published guides which list items wanted and firms who can supply them. In addition, it is considered good practice to maintain properly indexed manufacturers' catalogs listing items which might be desired and their unit prices. There is no substitute, however, for a file listing available qualified vendors who can provide specific items. This information also should be maintained in the stock record system, which will be discussed later in this article.

ISSUING THE PURCHASE ORDER

After the vendor has been selected, issuing the purchase order becomes a procedural matter. Good procedures for issuance and distribution of the purchase order help to insure the effectiveness of each purchase transaction. And these transactions add to the dignity of the hospital in its relations with the public.

Purchase orders should be pre-numbered, and should be issued in at least six copies, for distribution as follows:

—Three are sent to the purchasing office, one for

(Continued on page 52)

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(Continued from page 50)

the vendor file, sometimes called the alphabetical file; one for the numerical file; and one to serve as the voucher copy.

—One is given to the vendor.

—One is sent to the receiving clerk.

—The original is kept by the requisitioner.

In the alphabetical file, the copies should be arranged according to name of vendor. This file will provide valuable information on gross purchases from each vendor and will also make accessible, in one location, the cost data concerning prior purchases. The copy for the numerical file is used to maintain the numerical integrity of the purchase order system.

The voucher copy is probably the most important one of the set. After the purchase order has been issued, the voucher copy goes to the business office or the accounting department. There it is cross-matched with the requisition and placed in a special file. As soon as the receiving copy is forwarded, it is matched up with the invoices which have been received from the vendor. Then, the account is ready for payment.

If it is the practice of the hospital to pay only on monthly statement, the voucher copy provides an excellent means of verifying the statement and making certain that the hospital is only paying for what it has received. The accounting, or voucher copy, is used as a worksheet and may be destroyed after the transaction has been placed in line for payment. In a larger hospital's accounting department, the accounting copy may be used for budgetary control and for other purposes in the hospital.

As soon as the purchase order is issued, the receiving copy is sent to the receiving clerk, storeroom clerk, central supply supervisor, or other person designated to receive incoming merchandise. This copy should show clearly the vendor and the items ordered.

It should be the duty of the person receiving the merchandise to indicate on the receiving copy of the purchase order the exact amount received. In the case of fresh meat or items which are purchased by the pound, the receiving clerk should weigh the items to make certain that the hospital is getting what it ordered. This control can be exercised at no other point than that at which the material is received.

The receiving copy should be blanked out so that the receiving clerk has no way of knowing, at least insofar as the copy is concerned, what amounts were ordered or what their cost should be. Therefore the clerk is forced to enter on the receiving copy the exact amount or weight of the material actually received.

In hospitals of over fifty beds, it is recommended that an additional form be used, a receiving record which will be filled out and attached to the receiving copy. In smaller hospitals, however, the receiving copy of the purchase order will serve this purpose.

There are legal aspects relating to the conditions on the purchase order, and the wording on these orders always should be reviewed by the hospital's legal adviser. The order should provide, at the very minimum, protection against increases in costs after selection of the vendor, and against cancellations or changes in the order; a statement concerning the liability of the person signing the purchase order; and provision for return of goods which do not provide the quality required or promised.

The terms under which the hospital expects to secure its merchandise should be carefully and clearly printed on the copy which goes to the vendor. Statements concerning discount and payment of freight are extremely important.

If the hospital states plainly on its purchase order; "We will take 2 percent cash discount, 10th prox, unless invoice is clearly marked net," then the hospital is entitled to take a cash discount. Many vendors do permit a cash discount but do not advertise it or place notice of it on their invoices.

If a hospital specifies on its purchase order, "F.O.B. Hospital," and the vendor attempts to charge freight, under the common law the hospital may legally refuse to pay that freight. It is the duty of the vendor to refuse to accept the purchase order if it contains terms which are not acceptable to him.

If the hospital wishes samples with which to test a product, this fact should be clearly stated on the purchase order which goes to the vendor.

The preparation and distribution of purchase orders frequently requires excessive amounts of time. Often

(Continued on page 56)

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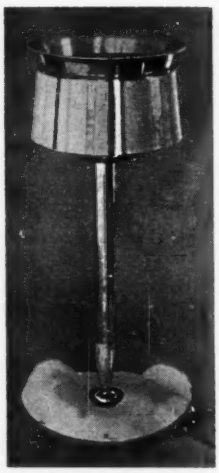

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Prove to yourself that WEXTEEL Scissors are the finest made—anywhere!

In scissors it is obvious that the actual cutting is done by the edges. And Weck Scissor edges are the keenest, hardest, longest lasting of any scissors made.

These edges are *not inserts* with the danger of future separation. They are an integral part of the blades. This means that the hardness is not limited to the edges. Actually the entire scissors are precision heat-treated to a super-high hardness and then tempered to impart maximum structural strength plus wear and corrosion resistance.

For edges to function properly blades must be in perfect juxtaposition—*permanently*. In Weck Scissors this is the result, among other things, of using a screw that is seated so perfectly that it prevents the edges of the blades from gouging into each other.

It also means that all parts at the fulcrum—the screw head, counterbored hole, etc.—are of a super-high hardness to practically eliminate wear.

Why not prove to yourself that WEXTEEL *Surgical Scissors are the finest made anywhere! Edward Weck & Company, Inc., 135 Johnson Street, Brooklyn 1, N.Y.*

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BUT IN MANY DISORDERS YOU GET

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IN CARDIAC CONDITIONS

ATARAX *is anti-arrhythmic.* In addition to producing tranquilization, ATARAX "restored and then maintained normal sinus rhythm" in 30 patients with cardiac arrhythmias. All had been refractory to standard measures.[1]

IN ALLERGIC REACTIONS

ATARAX *is antihistaminic, antiserotonin.* Tranquilizers usually have an equivocal effect on allergic disease; ATARAX appears to be the exception.[2] Feinberg reports "striking results" in 15 out of 17 patients with chronic urticaria that cannot be attributed to calming action alone.[2] To date, over 649 cases of allergic dermatoses have responded favorably to ATARAX.[3,4]

IN GASTRIC DISTURBANCES

ATARAX *is antisecretory,*[5] *antispasmodic,*[6] *and antitensive.* Both emotional and physical aspects of gastric disorders are controlled by ATARAX. Treatment of peptic ulcer, epigastralgia, aerophagia with painful eructations, and colic of spastic origin, has yielded promising results.[5,6]

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FOR MORE THAN ATARACTIC ACTION

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SUPPLIED: Prescription only. *Tablets*, 10 mg., 25 mg., and 100 mg., bottles of 100. *Syrup*, pint bottles. *Parenteral Solution*, 10 cc. multiple-dose vials.

1. Burrell, Z. L., et al.: Am. J. Cardiol. *1*:624 (May) 1958. 2. Feinberg, A. R., et al.: J. Allergy *29*:358 (July) 1958. 3. Eisenberg, B. D.: Clin. Med. *5*:897 (July) 1958. 4. Robinson, H. M., Jr., et al.: South. M. J. *50*:1285 (Oct.) 1957. 5. Strub, I. H.: Personal communication. 6. Schuller, B.: Gaz. des Hôpitaux No. *10*:391 (Apr. 10) 1957.

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(Continued from page 52)

this situation is caused by the preparation of a purchase order for each purchase from any vendor.

Many organizations have found that services and items which are procured in great volume from a limited number of suppliers may be efficiently purchased on monthly "blanket" orders. In this case, a purchase order is written each month to a particular vendor for the types of supplies which the vendor can furnish. The vendor usually is located in the community, or nearby, where reliability is insured and informal relationships are feasible.

Using this procedure requires the establishment of a second form which may be called a "pick-up purchase order." When supplies are required from a certain vendor, a pick-up order can be prepared informally in pencil and carried to the vendor's establishment by any employee, or the order may be telephoned to the vendor for delivery. In this procedure, the vendor usually is required to submit monthly invoices, supported by signed copies of pick-up orders or delivery slips.

In addition to reducing the time required for preparing purchase orders, this procedure has the advantage of reducing the number of vouchers and checks which must be handled by the business office. Application of this procedure often provides significant economies in time and money. It is not unusual to find that a hospital which maintains working relationships with 500 vendors issues 50 percent of the orders to as few as 15 or 20 different vendors.

FOLLOWING-UP AND EXPEDITING

During a period when materials are in long supply, and a buyer's market prevails, late deliveries are an infrequent problem. However, when a vendor delivers late consistently, it is best to obtain a new vendor.

It is the responsibility of the purchasing agent, to insure that deliveries are received when promised and when wanted. As a consequence, records must be maintained to account for the status of all orders.

Delays in delivery can be caused by faults in the ordering system. The most usual causes are failure to select a proper vendor; failure to provide a specific date for delivery; and issuance of a large number of rush orders. These problems can be alleviated by proper selection of the vendor, full agreement with him on the date of delivery, and reduction of rush orders.

Procedures for follow-up action normally are, and should be, simple. Colored tabs can be placed on the folders of purchase orders in the vendor file; these can indicate the delivery date desired. A daily review of these tabs can be made to determine those deliveries which are to be made soon and which should be checked. Also, the issuance of purchase orders can be recorded on the stock record cards which also can be tabbed for easy recognition of deliveries due.

Requests to vendors for status of deliveries usually are made by postcard, although a request for information or action can be made by telephone, if necessary. Ultimate recipients in the hospital always should be kept informed of difficulties encountered which may cause late deliveries.

RECEIVING AND INSPECTING

The purchase order should contain when issued, all directions for packaging, marking of the package, and delivery. This insures that deliveries will be made in a carton which contains the purchase order number and a description of the contents, thus minimizing the difficulties in recognizing the delivery.

The receiving point should be located in or near the stores area of the hospital, so that a member of the stores staff can receive and inspect deliveries, to insure that the proper item has been received and that the quantity is correct. The receiving clerk, or a member of the stores staff should be advised in advance of expected deliveries. He can maintain the purchase order file by vendor and perform all follow-up work.

The receiving clerk should be authorized to sign for deliveries and should prepare a receiving report immediately upon receipt. As noted previously, the vendor file copy of the purchase order can be used as a receiving report; in any case, carbon copies of the receiving report should be distributed to the business office and to the requisitioner, unless the items were purchased for stores.

Receipt of partial shipments not only should be noted on the purchase order receiving report, but also should be reported to the business office. Reports for partial shipments are often prepared on small machines designed for the purpose.

The receiving clerk should be responsible for determining that the correct items are received and that the quantity is right. Items which require the inspection of the technical or professional staff should be delivered immediately to the department head, who should insure that full inspection is made and that an inspection report is returned to the purchasing agent within 24 hours.

It has been found that, without such a procedure, incorrect items or items of low quality have remained in stores for many months before their inadequacy was discovered; then the purchasing agent was unable to return the item to the vendor.

Receiving reports, when completed, should be reviewed by the stock records clerk; receipts should be posted to the stock record cards, together with the location of the items in the storeroom.

CLOSING THE TRANSACTION

If invoices are sent to the receiving clerk, they should be forwarded to the business office; in fact, the purchase order should direct that invoices be forwarded to the business office. When the chief accountant has both the copy of the invoice and the receiving report, he should match them with the original purchase order, prepare the voucher, and make payment. Purchasing personnel should not be required to approve invoices for payment of items which they have purchased. But they should be required to reconcile invoices and purchase orders which appear to be in error with respect to item, amount, or price.

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BETTER HANDLING QUALITIES
NO BROKEN GLASS

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1. Alexander, Edythe L.: Mod. Hosp., May, 1957
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Regional Differences in U. S. Hospitals

By Louis Block, Dr. P.H.

Ninth in a series

• There are regional differences in the numbers and kinds of hospital facilities and services available, and in their utilization. The role of the regional hospital can best be portrayed by studying it as a part of the total United States picture, and as an entity in itself.

The largest value of plant assets in:

1. All hospitals was in the Middle Atlantic region.

2. Short-term general hospitals was in the Middle Atlantic region.

3. Nonprofit short-term general hospitals was in the Middle Atlantic region.

4. Proprietary short-term general hospitals was in the West South Central region.

5. Governmental (excluding federal) short-term general hospitals was in the Middle Atlantic region.

6. Long-term general hospitals was in the Middle Atlantic region.

7. Psychiatric hospitals was in the Middle Atlantic region.

8. Tuberculosis hospitals was in the South Atlantic region.

9. Federal hospitals was in the Middle Atlantic region.

Most of the plant assets in all regions are concentrated in short-term general hospitals. In this group, the nonprofit controlled hospital has the largest share.

In the West South Central region, the proportionate share of plant assets in proprietary and governmental (excluding federal) short-term general hospitals is greater than in other regions. Proportionately, the Mountain region has a higher share of its plant assets in federal hospitals than do the other regions.

*Based on the 1956 Administrators' Guide Issue, *Hospitals*, Journal of the American Hospital Association.

*Plant Assets**

1. The Region as a Part of the United States

Percent of	New England	Middle Atlantic	South Atlantic	East North Central	East South Central	West North Central	West South Central	Mountain	Pacific	Total
Total	7.4	24.9	12.4	20.4	4.8	9.1	7.6	3.7	9.7	100.0
Short-Term General	7.2	24.8	10.8	21.5	4.8	9.8	8.5	3.2	9.4	100.0
Nonprofit Short-Term General	8.9	27.1	9.5	24.3	3.7	9.6	6.2	3.3	7.4	100.0
Proprietary Short-Term General	1.0	10.1	17.9	4.5	12.1	9.3	30.2	3.0	11.9	100.0
Gov'tal (Excl. Federal) Short-Term General	3.2	20.0	13.9	15.5	7.2	10.1	12.5	3.2	14.4	100.0
Long-Term General	9.9	32.0	10.9	20.1	3.1	5.6	3.2	2.7	12.5	100.0
Psychiatric	8.5	27.2	11.5	25.4	3.3	10.1	4.4	2.2	7.4	100.0
Tuberculosis	6.9	19.8	21.9	19.3	8.9	6.6	4.1	4.9	7.6	100.0
Federal	5.7	21.9	16.3	11.2	5.9	7.6	11.1	6.7	13.6	100.0

2. The Region as an Entity in Itself

Percent of	New England	Middle Atlantic	South Atlantic	East North Central	East South Central	West North Central	West South Central	Mountain	Pacific
Short-Term General	51.8	52.7	46.1	55.5	53.0	56.4	58.7	46.7	50.9
Nonprofit Short-Term General	45.4	40.7	28.3	44.3	28.6	39.4	30.3	33.1	28.3
Proprietary Short-Term General	0.2	0.5	1.8	0.3	3.1	1.2	4.8	1.0	1.5
Gov'tal (Excl. Federal) Short-Term General	6.2	11.5	16.0	10.9	21.3	15.8	23.6	12.6	21.1
Long-Term General	5.7	5.4	3.7	4.1	2.7	2.6	1.8	3.1	5.4
Psychiatric	24.7	23.3	19.7	26.6	14.7	23.5	12.4	12.9	16.3
Tuberculosis	4.6	3.8	8.5	4.6	9.0	3.5	2.6	6.5	3.8
Federal	13.2	14.8	22.0	9.2	20.6	14.0	24.5	30.8	23.6
TOTAL	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

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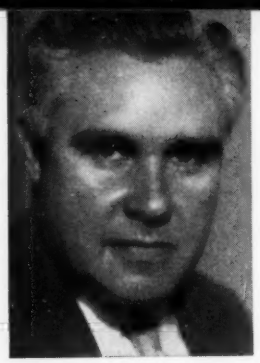


Consultant's Corner

By John G. Steinle

Q. How often should fire extinguishers be checked?

A. Fire extinguishers should be carefully inspected at least once a year. The annual inspection should include recharging, examination of gaskets and hoses, and replacement of parts when indicated. Some types of extinguishers require hydrostatic examination, to detect leaks, at least every five years. Substantial records are necessary to assure that extinguishers are maintained in good operating condition. Some hospitals have found it more economical to contract for a maintenance service. Such maintenance usually includes the servicing of soda-acid and foam type extinguishers at the hospital. Fresh chemicals and solutions are added, gaskets and hoses replaced when necessary. Other types of extinguishers, such as carbon-dioxide and dry-chemical models, are taken to the plant for service and returned in a few days. Usually replacements are left so that the hospital is covered in the interim.

Q. In determining hospital bed needs for a community, is the Hill-Burton formula of 4.5 beds per thousand population a good criterion to use?

A. No, it is not a good criterion for a single community. The ratio of 4.5 beds per thousand population is part of a formula that sets the upper limit for federal assistance to states. The total formula provides for 2.5 beds per thousand in rural areas, 4.0 beds in intermediate areas, and 4.5 beds in urban or "base" areas. It also permits the state agency flexibility in allocation of "pool beds" to communities.

There are many factors in addition to gross population that should be considered in determining hospital bed needs of a community. In every instance, a detailed study of the community's individual needs should be made before beds are constructed. Some of the factors that should be considered are:

—Type and quality of medical care; the number of specialists in the area.

—Number of people who will go elsewhere regardless of local facilities; location of hospital in relationship to urban centers.

—Birth rate of area to be served.

—Extent of Blue Cross and other prepaid insurance coverage.

There are many studies being made, and data are being developed that provide a better understanding of hospital utilization. A very extensive study of prepaid hospitalization by the State of New York Insurance Department has provided the number of annual hospital days by age groupings for persons with coverage. Presumably persons with complete coverage would receive all necessary hospitalization in a state with extensive facilities, on a statewide basis. Projecting the utilization figure of those with 120-day maximum illness benefits to the entire population and adding the need for total births, at 80 percent occupancy, only 4.1 beds per thousand population are indicated.

The Hospital Council of Baltimore has taken the position that the most effective means of avoiding over-utilization and abuse of Blue Cross is to limit the number of available beds. According to this concept, the Hill-Burton formula of 4.5 beds per thousand population is too high.*

Q. The state medical society is contacting hospitals to recommend that a physician be placed on the board of trustees of each hospital. What do you think of this proposal?

A. It is dangerous and contrary to the best interests of hospitals. The principal objections to physicians as members of hospital boards of trustees are these:

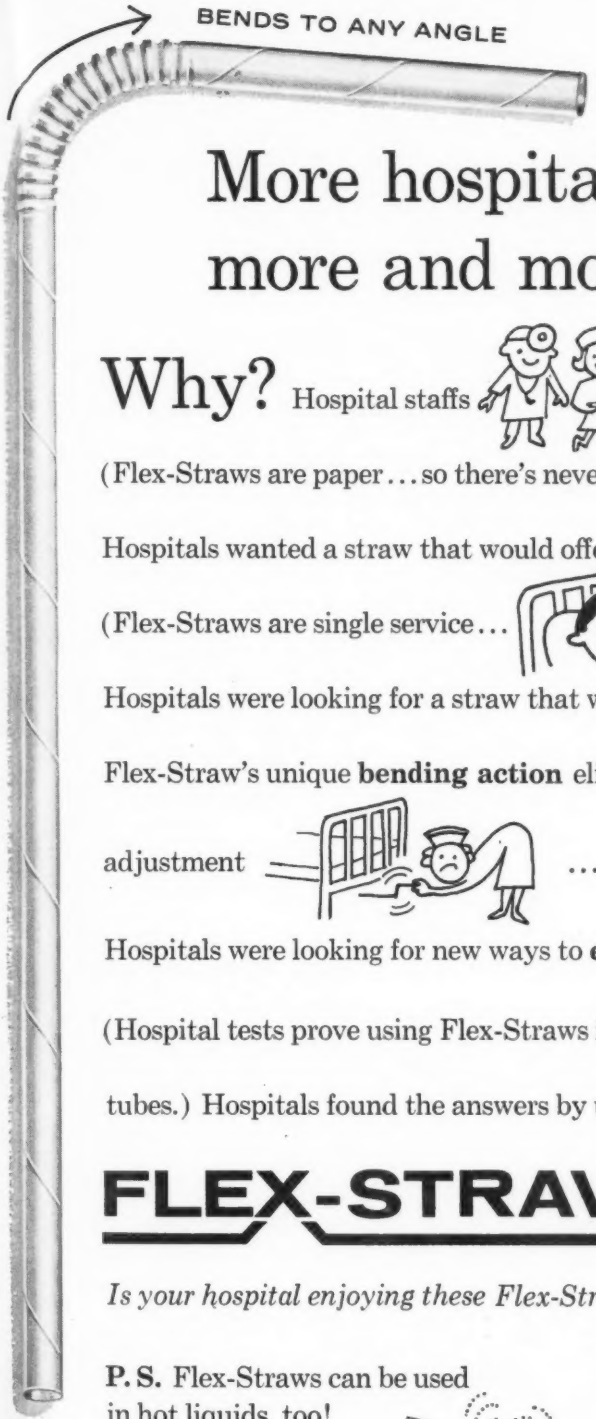
1. A conflict of interest is present. It is impossible for the physician to view the total operation of the hospital dispassionately and objectively.

2. The physician obtains a superior position over other staff members. Membership on the board of trustees places a physician in a particularly advantageous position both within the hospital and in the eyes of the community.

3. Other trustees tend to defer to him. Experience has proved that other trustees tend to depend on the physician's opinion and view him as an "expert" in hospital affairs even in areas that have nothing to do with medical staff activities and those about which he has little knowledge.

4. A physician-trustee often diverts the board from policy matters and involves it in operating problems. Since he is directly concerned with certain aspects of the hospital operations, the physician-board member often emphasizes the operating problems rather than broad policy matters.

*Further discussion of this question, illustrated with tables, may be found in "Consultant's Corner," HOSPITAL TOPICS, May, 1957, page 51.



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Hospitals wanted a straw that would offer their patients added **cleanliness**

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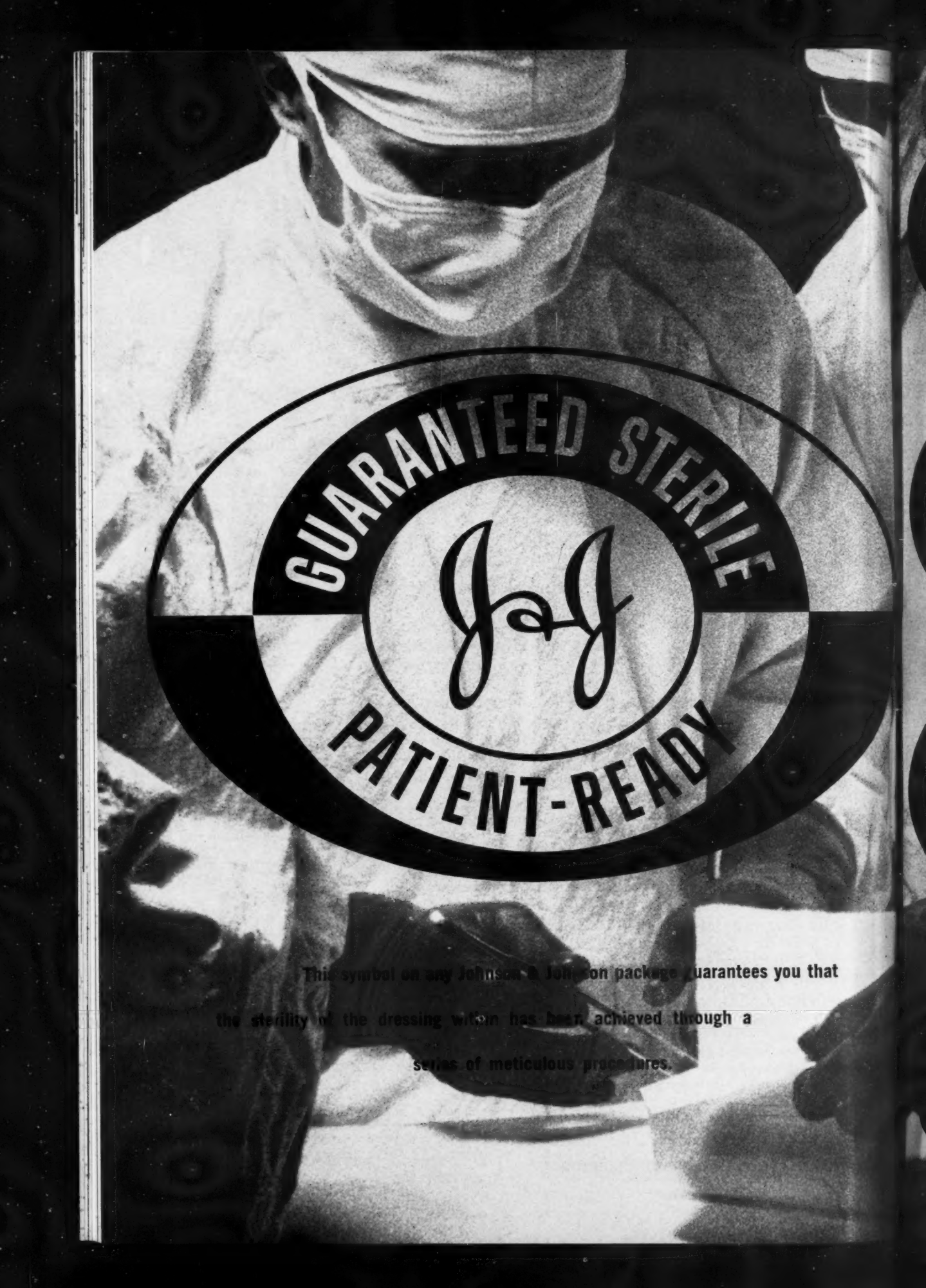
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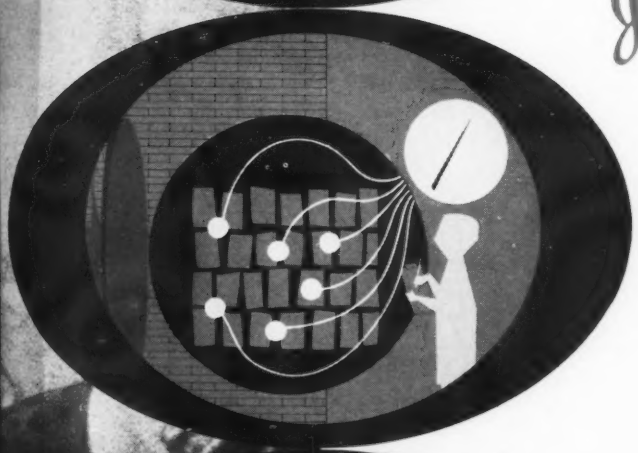

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Review of Hospital Law Suits

By Leo Parker, Attorney at Law

• It is important to note that courts give great weight to testimony taken from hospital executives and employees who understand their legal rights and obligations. This is so because these persons are less likely to perform acts or make contracts that will result in liability than are persons who are unfamiliar with elementary law and have no dependable legal knowledge or who rely upon "hearsay" information which, in the majority of instances, is quite undependable.

Obviously, the higher court decisions cited here may be used advantageously by readers and lawyers to win unavoidable law suits. Readers will do well to clip and file these article for future reference.

MOTHER'S ESTATE IS LIABLE

An official of a hospital corporation asked this legal question: "Can a hospital collect, from a deceased mother's estate, support and maintenance of her daughter, if the mother left her estate by her will to another person?"

A few weeks ago a higher court rendered an opinion answering this legal question in the affirmative.

For instance, in Department of Mental Hygiene v. Laurence McGilvery, 316 Pac. (2d) 46, the testimony showed these peculiar facts: A mother, named Joan McGilvery, was adjudged mentally ill and sent to the state hospital in 1935. Laurence McGilvery is Joan's son. He is now past the age of majority. Annie Girard was Joan's mother, Laurence's grandmother. Annie died in 1955 at 83 years of age. In her will she left Laurence her estate. The appraisal of her estate was $18,984.69.

The state hospital presented a claim for $4,737 to the executor for Joan's support and maintenance for the four-year period preceding Annie's death. The claim was rejected by the executor.

In subsequent litigation, the higher court held that the state hospital was entitled to collect, from the $18,984.69 left by Annie, payment of its claim of $4,737 for Joan's support and maintenance. This court said:

"In our modern and enlightened treatment of the mentally ill, the people of our state must bear the cost; but it is only right that relatives of patients in our state mental hospitals should, to the best of their ability, assume as much of it as they fairly can. Annie was liable for Joan's support and treatment in the hospital."

HIGHER COURT UPHOLDS COMMISSION

Generally speaking, a higher court will uphold a state industrial commission's award of compensation to an injured employee under the State Workmen's Compensation Act. This is so although a lower court may reverse the holdings of the commission.

For instance, in Crisp v. McBride Bone and Joint Hospital, 317 Pac. (2d) 198, it was shown that a woman named Crisp filed a claim for compensation against her employer, McBride Bone and Joint Hospital. She stated that while in the employ of the McBride hospital, she sustained accidental injuries consisting of injuries to her back; that such injuries were caused by lifting patients in the hospital into their beds; that as a result of such injuries she sustained some permanent disability to her person.

The state industrial commission refused to award compensation to Crisp on the grounds that there was no definite proof or testimony that she sustained her injuries lifting patients. Crisp appealed to the lower court, which held that Crisp, while in the employ of McBride Bone and Joint Hospital, sustained accidental injuries consisting of injuries to her back; that as a result of such injuries she was temporarily totally disabled; that her average monthly wages were sufficient to fix her compensation rate at $24.62 per week, plus $590.88 past earned compensation.

The case was appealed to the higher court which listened to Crisp's testimony that her back injury resulted from lifting patients in the hospital. She offered no medical testimony. Two doctors submitted reports of their medical examinations; their conclusion was that Crisp did not sustain an injury and had no organic injury.

The higher court reversed the lower court and upheld the commission's decision that Crisp was not entitled to compensation, saying:

"While it is true that the medical evidence is conflicting and in some respects indefinite and uncertain we cannot say that there is no competent evidence reasonably tending to sustain the finding of the commission. Findings of fact made by the state industrial commission are conclusive and binding upon this court, where there is any competent evidence reasonably tending to support such findings."

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*AUTIAN, J., AND BREWER, J. H.: AM. J. HOSP. PHARM. 15:313, 1958.

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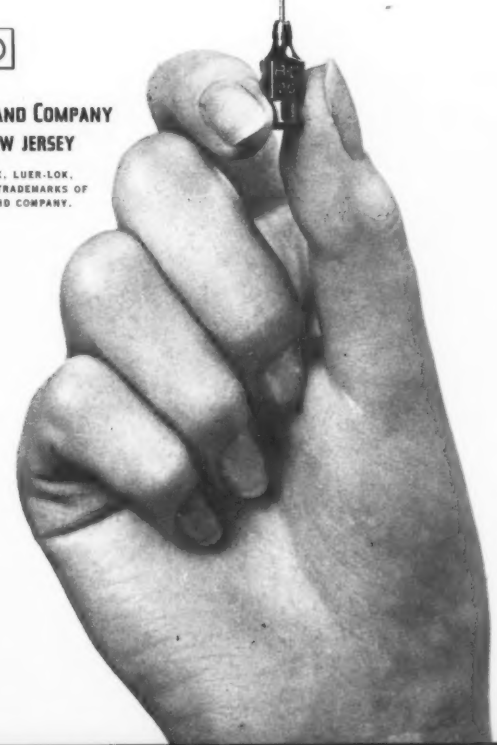
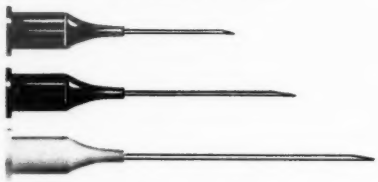


DISCARDIT

HYPODERMIC EQUIPMENT

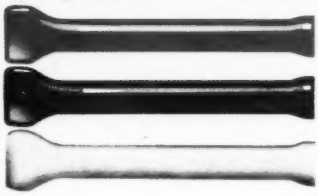
COLOR-CODED for easy identification

YALE
Sterile Disposable Needle



25 GAUGE
22 GAUGE
20 GAUGE

HYPAK Sterile Disposable GLASS
Syringe-Needle Combination



PACKAGED for hospital convenience

YALE STERILE DISPOSABLE NEEDLES—for all B-D Luer-Lok and Luer-Slip Syringes

Catalog No.	Gauge	Color Code
HSYN	25 Gauge x 5/8"	(Blue)
HSYN	22 Gauge x 1"	(Black)
HSYN	22 Gauge x 1½"	(Black)
HSYN	20 Gauge x 1"	(Yellow)
HSYN	20 Gauge x 1½"	(Yellow)

100 needles (20 strips of 5) in sturdy package with handy slide-off sleeve for disposing of used needles. Shelf package: 1000 needles. Case: 5 shelf packages (5000 needles)

HYPAK STERILE DISPOSABLE GLASS SYRINGE-NEEDLE COMBINATION

A702	2 cc. with 25 x 5/8" needle	(Blue)
A702	2 cc. with 22 x 1" needle	(Black)
A702	2 cc. with 22 x 1½" needle	(Black)
A702	2 cc. with 20 x 1½" needle	(Yellow)

Individual unit in sealed polyethylene bag. 20 units per box. Shelf package: 25 boxes (500 units). Case: 2 shelf packages (1000 units).

B-D CONTROLLED your assurance of sterility

On all sterile, disposable DISCARDIT products, B-D supplements federal sterility controls by introducing with each product lot undergoing sterilization, red-marked products contaminated with organisms known to be resistant to the sterilizing agent. B-D passes production lots only if post-sterilization tests establish the sterility of both regular product samples and the extra red-marked control samples.

B-D **BECTON, DICKINSON AND COMPANY · RUTHERFORD, NEW JERSEY**

in Canada BECTON, DICKINSON & CO., CANADA, LTD., TORONTO 10, ONTARIO

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55458

Personally Speaking

M. R. Kneifl, executive secretary, Catholic Hospital Association, receives congratulations, with his wife, Eleanor, at special reception commemorating his 35th anniversary with the association. Reception was held during the annual CHA convention in June in Atlantic City, N.J.

Mrs. Annie Ruth Allen, R.N.—is superintendent of nurses, Neshoba County Hospital, Philadelphia, Miss.

Dan Altshuler—administrator, C. J. Harris Community Hospital, Sylva, N.C., recently resigned to become administrator of a hospital in LaFollette, Tenn.

Mrs. Josephine Armstrong, R.N.—is the nurse-anesthetist and superintendent of nurses, Grant Memorial Hospital, Petersburg, W. Va. She was previously with the Medical College of Virginia, Richmond.

William A. Barrett — formerly assistant administrator, Georgia Baptist Hospital, succeeds **William H. Thrasher** as administrator, Athens (Ga.) General Hospital. Mr. Thrasher is administrator of the proposed new hospital in DeKalb County, Ga.

Carl R. Baum—has been named director, Children's Hospital of Philadelphia. He was formerly acting director.

John L. Byrne — has been appointed administrator, Children's Medical Center, Tulsa, Okla. He was formerly administrator, Ruth Lodge Center, Chicago.

Arel B. Cook—has been appointed associate administrator for hospitals conducted by the Franciscan Sisters of the Immaculate Conception in Minnesota and Wisconsin.

Named to the newly created position of consultant in nursing for these hospitals is **Sister Mary Elizabeth, O.S.F.**

Robert S. Cooke, Jr., M.D.—is pathologist, Greenwood (Miss.) Leflore Hospital.

Robert E. Cundiff—succeeds **Fred Ellison** as administrator, Tri-City Hospital, Leaksville, N.C. Mr. Ellison has become administrator of a South Carolina hospital.

John L. Cutler, M.D.—former acting superintendent, has been appointed superintendent, Tinley Park (Ill.) State Hospital.

Ed Cramer — formerly of Children's Mercy Hospital, Kansas City, Mo., has succeeded **Nathan Johnson** as administrator, Wilson County Hospital, Neodesha, Kans. Mr. Johnson has taken a similar position in Nampa, Ida.

Joseph E. Duty, M.D. — is new superintendent, Toledo (O.) State and Receiving Hospitals. Former superintendent **Joseph Garland, M.D.**, will remain on the staff as clinical director.

Theodore Frazier — succeeds **James P. Neal** as administrator, Wheatley-Provident Hospital, Kansas City, Mo. Mr. Neal is now at Community Hospital, Evanston, Ill.

Norman E. Girard—is new assistant administrator, Rolling Hill Hospital and Diagnostic Center, Elkins Park, Pa. He had been administrative resident, University of Colorado, Denver.

Harry Goodman, M.D. — has been named superintendent, Northampton (Mass.) State Hospital. He succeeds **J. H. Fernand Longpre, M.D.**, who has retired.

Mrs. Mary Quinn Griffith, R.N.—has been appointed director of nursing services, Doctors Hospital, San Diego, Calif. She was formerly supervisor of nursing administration, Scripps Memorial Hospital, La Jolla, Calif.

John A. Harrison—replaces **Dan Traner** as administrator, Lynn (Mass.) Hospital. Mr. Harrison had been assistant administrator, Truesdale Hospital, Fall River, Mass.

Earl Ireland—has been appointed administrative assistant, Memorial Hospital, Colorado Springs, Colo. He was formerly administrator, Memorial Hospital, Sheridan, Wyo.

Herbert L. Goodman, M.D.—has been appointed pathologist and director of the laboratory, East Orange (N. J.) General Hospital. He was formerly assistant pathologist, Bryn Mawr (Pa.) Hospital.

Edward E. James—has joined the institutional management division of Booz, Allen & Hamilton, management consultants. Mr. James was at one time director, Butterworth Hospital, Grand Rapids, Mich., and most recently, operated Hospital Management Services, Grand Rapids.

Paul S. Jarett—former chief, West Valley Community Hospital, Hollywood, Calif., has been named administrator of Sherman Oaks Hospital in Hollywood.

Madeline Kennedy, R.N.—assistant professor, department of nursing, University of Rochester, has been appointed to the New York

(Continued on next page)

State Board of Examiners of Nurses. Before joining the university staff, she was assistant chief of nursing, VA Hospital, Buffalo.

Albert E. Koch—community survey consultant, division of hospital services, is now administrator, Elk's Aidmore Hospital, Atlanta, Ga.

J. Herbert Maltz, M.D.—has been appointed superintendent of Chicago State Hospital, succeeding **Kalman Gyarfas, M.D.**, who is returning to the University of Illinois. Mr. Maltz has been on the staff there ten years.

Stuart Marylander — administrative assistant, Cedars of Lebanon Hospital, Los Angeles, has been named assistant administrative director.

Donald Masar—is now business manager, Lawrence (Kans.) Memorial Hospital. He was formerly credit manager, St. Mary-Corwin Hospital, Pueblo, Colo.

Verdamae Karr McKee — is new superintendent, Dixon (Ill.) State School Hospital, succeeding **Robert E. Wallace.** She had been assistant superintendent, East Moline (Ill.) State Hospital.

Kenneth S. Meredith — succeeds **Thomas Paden** as administrator, Bedford County Memorial Hospital, Everett, Pa. Mr. Paden is assuming duties as administrator, Citizens General Hospital, New Kensington, Pa. Mr. Meredith formerly was administrator, Cafaro Memorial Hospital, Youngstown, O.

Mrs. Helen E. Miller—is full-time director of volunteers, Sherman Hospital, Elgin, Ill. She succeeds **Mrs. J. G. Massey.**

Ken Neese—is new assistant administrator, Moore County Hospital, Pinehurst, N.C., succeeding **Thomas M. Surratt**, who resigned to become assistant administrator, Rowan Memorial Hospital, Salisbury, N.C.

Howard H. Peppel — has been named acting superintendent, Hawthornden State Hospital, Macedonia, O. He had been director, Moundbuilders Guidance Center, Newark, O., a community mental health clinic.

Margaret E. Peters, R.N.—has assumed duties as administrator, Institute of Physical Medicine and Rehabilitation, and as assistant administrator, University Hospital of New York University-Bellevue Medical Center, New York City.

Ben Piazza—has resigned as head, physical therapy department, Mercy Hospital-Street Memorial Hospital, Vicksburg, Miss., to accept a similar position at University Hospital, Jackson, Miss. His successor is **Mrs. Max Klaus.**

Mary Ann Ramsey — has been appointed director, health education and public relations, Lankenau Hospital, Philadelphia.

John Reedy—has succeeded **Clifford Johnson** as business manager, Forrest County General Hospital, Hattiesburg, Miss. Mr. Johnson is now administrator, Jefferson Davis County Hospital, Prentiss, Miss.

Jack Rue—former administrator, McCurtain County Memorial Hospital, Idabel, Okla., has become administrator, Hot Spring County Memorial Hospital, Malvern, Ark.

Stuart A. Shortt—has resigned as administrator, Massac Memorial Hospital, Metropolis, Ill.

Sister Andrew — director, Good Samaritan Hospital School of Nursing, Dayton, O., will direct the School of Nursing, Good Samaritan Hospital, Cincinnati, O. Succeeding her is **Sister Ann Seton**, director of nursing services.

Sister Mary Cortona, O.S.F. — is new director of nursing, St. Gabriel's Hospital School of Nursing, Little Falls, Minn.

William Slabodnick—has resigned as assistant administrator, Massillon (O.) City Hospital to become administrator Fisher-Titus Memorial Hospital, Norwalk, O.

Martin Sloane, M.D.—is superintendent, East Moline (Ill.) State Hospital. He was formerly acting superintendent.

Mrs. Joann Smetana — has been named superintendent, Phillips County Community Hospital, Phillipsburg, Kans.

Robert Spencer, M.D. — has resigned as radiologist, Piqua (O.) Memorial Hospital. **Edmund Saunders, M.D.**, has been named in his place.

Velma Thompson, R.N.—is superintendent of the new Osborne (Kans.) Memorial Hospital.

Leroy True—has been elected administrator, Nantucket (Mass.) Cottage Hospital. He was formerly chairman of the hospital's maintenance committee.

Kolbein K. Waering, M.D. — has been appointed director, Southeast Ohio Tuberculosis Hospital, Nelsonville, O. He succeeds **Harold Cashman, M.D.**, who has resigned.

Janet C. Wien—has become chief, social service department, Boston Dispensary, New England Medical Center, Boston. She has been chief of social service, Duke Hospital, Durham, N.C.

Lilyan C. Zindell—has resigned as administrator, Perry County Memorial Hospital, Perryville, Mo., to become consultant and executive director of a new general hospital-geriatric unit to be located in Fredericktown, Mo.

VA Appointments

Turner Camp, M.D.—chief medical officer, VA outpatient clinic, Los Angeles, succeeds **Arthur J. Klippen, M.D.**, as director of clinics, VA department of medicine and surgery, Washington, D.C. Dr. Klippen has been appointed director of hospitals in the department.

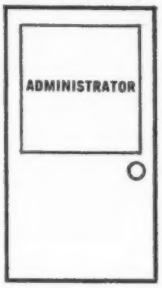
Ralston Wells, M.D.—has retired as manager, VA Hospital, Grand Island, Nebr. Dr. Wells has been with the VA since 1946 and managed hospitals at Jackson, Miss., and Dallas, Tex., before moving to Grand Island.

(Continued on page 136)

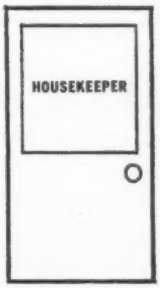
Sufficient detergency to satisfy the Housekeeper, efficient disinfection to satisfy the Professional Staff, lighter labor costs to satisfy the Administrator, and minimum costs of best supplies to satisfy you - Tergisyl offers all.

Better control of cross infection through simplified procedures is possible with the one-step Tergisyl method of disinfecting and cleaning. Reservoirs of staph, other common pathogens, and TB bacilli are destroyed routinely, efficiently with less effort.

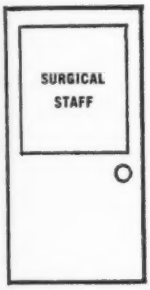
For every 100,000 square feet of floor space in your hospital now cleaned and then disinfected by man-and-mop-and-pail, you can save as much as 5 man days per week, or 40 man hours, by adopting the one-step Tergisyl method.



Complete twice the work in half the time – and save money on both labor and materials. One-step Tergisyl cleaning procedure – which includes dependable disinfection – is quickly accepted, easier to follow.



Lehn & Fink's new weapon to combat cross infection



Best defense against spread of staph is careful attention to total environmental asepsis, including floors. With the Tergisyl method, efficient general disinfection is simultaneous with routine cleaning.

Tergisyl T.M.

DETERGENT–DISINFECTANT

Cuts labor cost 47%

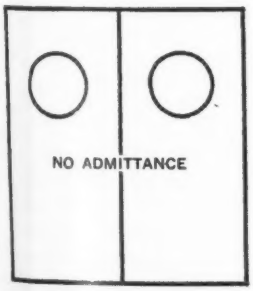
(by mop-and-pail method)

Cuts labor cost 22%

(by machine scrubbing-vacuum method)

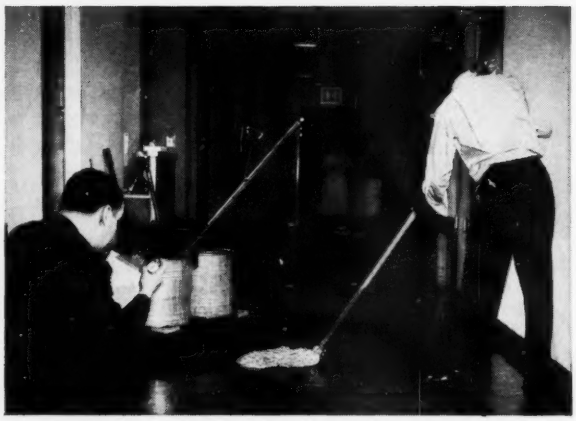
Cuts material cost 5% to 10%

(using either of above cleaning-disinfecting methods)

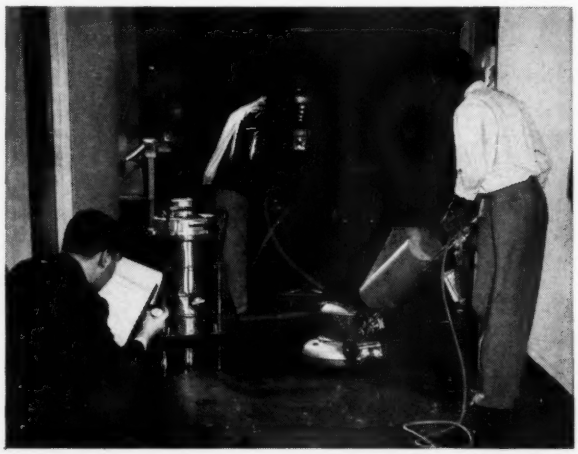


Keeping the O.R. "clean" in every sense of the word is easier, quicker with the new Tergisyl technic. Efficient disinfection and dependable detergency are combined in one cleaning step to achieve environmental asepsis you can be proud of. Has no effect on conductivity.

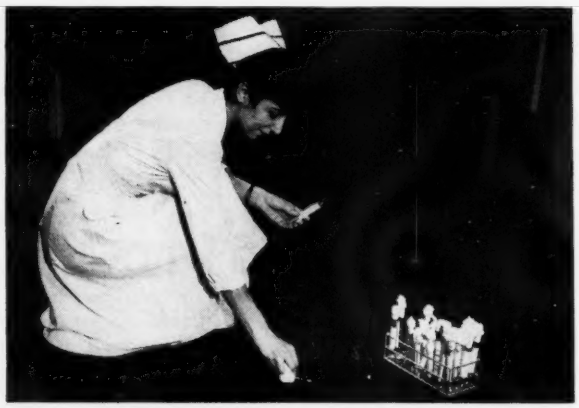
For details of comparative time studies under actual hospital conditions– TURN PAGE



Comparative time studies of Tergisyl vs. conventional method washing and disinfecting using mop-and-pail technics. One-step Tergisyl method reduced the man-time required by 47%. Actual time saved was approximately 25 minutes per 1,000 square feet of floor area—a labor saving of 125 man hours or 15 man days per week in a 300-bed hospital.



Comparative time studies of Tergisyl vs. conventional machine scrubbing vacuum pickup, and mop-and-pail application of disinfectant. One-step Tergisyl method reduced the man-time required by 22%. Actual time saved was approximately 23 minutes per 1,000 square feet of floor area—a labor saving of 20 man hours or 2½ man days each week in areas of heavy soil in a 300-bed hospital.



Comparative cleaning and disinfecting efficiency of Tergisyl vs. conventional method. Subsequent inspection showed greater cleaning ability for Tergisyl than the detergent previously judged acceptable by the hospital. "Before" and "after" bacteriological tests confirm germicidal efficiency of Tergisyl.

Three years of research backed by over sixty years of experience have produced Tergisyl, detergent-disinfectant

Since control of cross infection, especially from Staph, has become a major problem for hospitals, Lehn & Fink has felt an increasing responsibility to do everything possible to aid in this fight. Producing the most efficient disinfectants for hospital use has been our chief concern for many years. In addition, we have tried to supply these disinfectants in as practical and easy-to-use a form as possible so that the hospital could devote its attention to actual medical and surgical care of the patient.

Seriousness of the Staph problem has now made more adequate and dependable disinfection a necessary part of patient care. Development of Tergisyl, combining the comprehensive bactericidal, fungicidal, tuberculocidal efficiency you have come to expect of our products with sufficient detergency to clean even heavy soil satisfactorily, took many years of research. An independent research organization has confirmed our findings under actual hospital conditions.* But the most convincing test of Tergisyl's labor-saving advantages is use in your own hospital. We hope you will try it. Why not write immediately for your free sample and literature?

*Details of report available on request.

For metered mixing of Tergisyl and water in the proper proportions directly from the faucet—Use the L&F ECONOMIX™ PROPORTIONER

No more mixing and measuring. With the press of a button, the right proportion of Tergisyl is automatically released with the cleaning water. A carefully designed, stainless steel attachment which saves time, assures efficient use dilution every time. Same faucet can still be used for clear water.

Write for Tergisyl brochure and additional information about the convenient Economix.

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PRODUCTS CORPORATION DIVISION
445 PARK AVENUE, NEW YORK 22, N.Y.

The Hospital Pharmacy and Public Relations

By Alex M. Milne*

• No one will deny that the operation of hospitals in this country has become "big business." Whether we define the size of the business by the number of personnel on the payroll, by the number of customers serviced (in hospitals, by the number of patients served), or by the amount invested in buildings, equipment, and grounds, we find that hospitals rank among the first five of America's largest businesses or industries.

Therefore, it is only logical that the best practices of big business should be adopted by hospitals. In doing so, let us not overlook the all-important factor of public relations.

It is necessary to understand some of the general aspects of public relations in order to realize better what the pharmacy can contribute to the over-all PR program of the hospital. Further, it is important to get away from the idea that public relations consists only of publicity, which is in reality but one phase of a large and complex program.

Public relations is part and parcel of the hospital, as much a part of it as the bricks of the building. There is no beginning and no end to public relations.

It affects every department of the hospital and no one can escape it. So, since the hospital is going to have public relations—why not make it good?

What is public relations in a hospital? According to a 1934 definition by the Commission on Public Education of the American Hospital Association, it includes "a co-operative plan of utilizing every possible legitimate and ethical means of informing the public of the benefit it can expect to derive from its hospital."

Why does the hospital need good public relations? It needs good relations with the public because it needs friends. It is a public service organization. As such it is under constant and critical scrutiny by the community, the patient, his family and his friends, and its own staff and employees. The reaction of a visitor to the hospital may carry as much weight in the community as the reaction of a patient.

This continuous scrutiny of the operations of a hospital by its entire staff as well as the community it serves, necessitates a program of education which is one of the basic beams in the structure of public relations. The hospital owes it to the community to do a good job but it can't do a good job without public acceptance and support; this will only come after public understanding of the hospital's hopes, aims, and problems.

The influence of public relations is really emphasized when a hospital finds itself in the position of going into its community to ask for funds. The community's response to the fund raising drive is an easy-to-determine measure of whether the hospital's public relations has been good or bad.

How do public relations serve a hospital in its relations with a community? The hospital, the patient, and the community can all gain through the spread of knowledge which gives a true picture of the service, value, and importance of the hospital in the life of the community.

For the hospital—public relations means a better understanding by the public of the hospital's (a) contribution to community, health, employment, and economics; (b) role in the care of indigent patients, especially its help in meeting the problems of payment; (c) need for adequate and up-to-date plant and equipment; (d) personnel problems, including staffing, and need for community assistance in attracting personnel; and (e) continuous readiness to serve.

For the patient—public relations means realizing that the service is adequate in quality, pleasant, efficient, and effective; and having the assurance that the cost of service is as low as possible.

For the community—public relations brings an understanding of current hospital activities, problems and progress; and the assurance that the hospital's services will be available when needed.

MUST INFORM PUBLIC

Few will dispute the fact that good public relations is essential to the success of any undertaking which involves contact with large numbers of people. A prerequisite, of course, is having a good product and then informing the public about it. Industry spends billions of dollars each year to perfect its products before they are put on the market.

More than passing thought should be given to our product — health care. Is that care all it should be? The AHA says: "Your best public

(Continued on next page)

*Chief, Equipment and Planning Branch, Division of Hospital and Medical Facilities, U.S. Public Health Service.

relations is good patient care." How right that is! The respect of the community for the hospital—once it understands what the hospital contributes to community life—is governed by the quality of care given patients. In hospitals as in other businesses, the best ad is a satisfied customer.

It must be remembered that the hospital business is highly personalized. Hospitals and their services affect most people one way or another all of the time. On their reactions depend community acceptance or rejection.

The pharmacy plays an important part in the modern hospital and hence, in its relations with the community. An adequate pharmaceutical service is not only an element of a good hospital public relations program but is a "right" to which the patient is entitled.

The hospital of today is rapidly assuming the role of the health center of the community. The modern medical commodity is in reality a fusion of curative medicine and preventive medicine, providing a program of "health maintenance." Such a program requires a symphony of effort by many members of the health team in a co-ordinated and integrated manner. It is at the hospital that we find the crises and often the crucial test of that co-operative endeavor on behalf of the patient.

The "operating room with attachments" of yesteryear is vanishing; by comparison, even the small community hospital today is a real medical center. Chemotherapeutic agents and pharmaceuticals are essentials of patient care, and it is only right that their selection, use, control, and disposition be carried on by competent personnel. Hence, the qualified pharmacist is an important member of the health team.

PR ACTIVITIES VARIED

Public relations in the pharmacy may stem either from activities which involve points of public contact or from those which do not. A well-organized pharmacy contributes to the good integration of the whole hospital organization. Not only is it the department from which all medications are supplied to the various nursing units and in which special prescriptions are filled for patients, it is also the department in which the medical, nursing, and other staff members may find helpful consultative advice relative to current drug therapy.

The nursing units and outpatient departments utilize the bulk of the pharmaceutical service; eventually, however, this service is extended to practically every department of the hospital. The surgical department requires germicidal solutions, anesthetics, and other medications; the emergency room needs antidotes and other drugs for emergency conditions; the outpatient department, in addition to needing prescription-filling for patients, also requires medications for use in the clinics; the laboratory obtains reagent solutions from the pharmacy; the x-ray department needs radiopaque agents.

The pharmacy must also co-ordinate its services with the work of

(Continued on page 72)

SINCE 1885, fine quality catheters have been the prime product of RUSCH. Now one of the largest manufacturers in the world, RUSCH employs over 700 skilled workmen to produce thousands of different catheters. You can rely on RUSCH for your every requirement in catheters.

BASIC TYPES: BALLOON RETENTION CATHETERS • PEZZERS • MALECOTS • NELATONS • ROBINSONS • TIEMANNS • WHISTLE TIP • T-TUBES • DE LEE • NASAL OXYGEN • MILLER-ABBOTT & OTHER INTESTINAL TUBES • RECTAL & COLON TUBES • ESOPHAGEAL BOUGIES • CARLENS DOUBLE LUMEN CATHETERS • BRONCHOSPIROMETRIC CATHETERS • RED RUBBER AND PUREST LATEX • RUSCHELIT PLASTIC URETHRAL & URETERAL CATHETERS & BOUGIES • CARDIAC CATHETERS • STYLETS • SPLINTS • FOLLOWERS.

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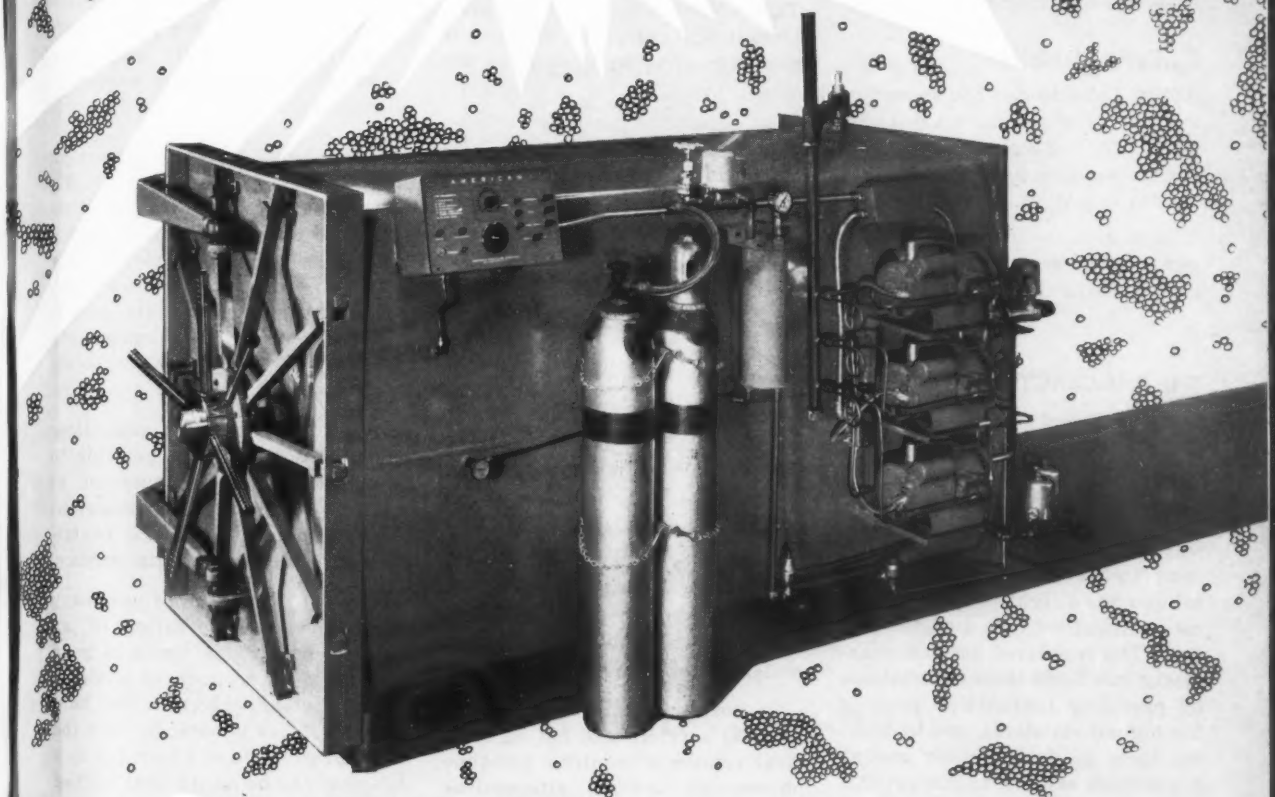
A *NEW* WEAPON IN THE WAR AGAINST STAPH!



AMERICAN

MATTRESS *and* BEDDING DISINFECTOR *with special* LOADING CAR

A special-purpose Ethylene Oxide unit combining minimum investment and low processing cost with simple, effective operation

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AMERICAN STERILIZER
ERIE • PENNSYLVANIA

Write today for bulletin SC-306

prescription pad

Phenylketonuria Control

Lofenalac is an infant formula product introduced by Mead Johnson & Co. for dietary management of phenylketonuria.

Protein component of the formula is a special casein hydrolysate from which most of the phenylalanine has been removed to provide control of the disease. Also included is a balanced group of dietary nutrients.

Lofenalac is supplied as a powder, in 2½-lb. cans, on a demand-only basis to avoid overstocking.

Radiation Inhibitor

Abbott Laboratories has announced availability of the radiation inhibitor, AET (2-aminoethylisothiouronium bromide hydrobromide), in limited quantities.

In studies, the compound has protected mice against x-irradiation, and potential uses as an enzyme activator and as a free radical detoxifier have been indicated.

AET is an odorless, white crystalline powder. Active protective agent appears to be 2-mercaptoethylguanidine hydrobromide (MEG), to which AET is quantitatively converted with the liberation of a free sulfhydryl group on neutralization to pH 7.

AET is supplied through Abbott's Chemical Sales Division.

New Germicide

Betadine antiseptic, introduced by Tailby-Nason Co., is a broad-spectrum topical germicide, designed to minimize irritation of skin and mucosa.

A complex of povidone and iodine, it offers one percent available iodine. It can be used against bacteria, viruses, fungi, and other organisms.

Betadine antiseptic is supplied in 1-pint bottles.

THE PHARMACY

(Continued from page 70)

the business office in pricing and in submitting charges and credits.

Most important of all is the pharmacy's service to the patient. He is completely dependent on the hospital and has a right to expect medication dispensed by a qualified person. The registered hospital pharmacist can fulfill these expectations by providing medications meeting the highest standards, and by making them available quickly and at a minimum expense to the patient.

These are the activities which, if not based on actual points of contact, are at least identified with efficient patient care. Successful handling of these functions is part and parcel of good public relations.

Many smaller hospitals, particularly those with less than 50 beds, do not employ a pharmacist. Yet the small hospital is expected to maintain the same professional and legal standards as those which are taken for granted in the larger hospital — without the same resources. And surely a pharmaceutical service which meets such standards is essential.

The magnitude of this problem is even more evident when we note that over a third of the nation's 5,300 general hospitals have less than 50 beds. These hospitals admitted two and one-quarter million patients last year.

In hospitals in which pharmaceutical services are not of sufficient volume to require a full-time pharmacist, several alternatives can be employed to maintain good service.

Some small hospitals have solved their problem by securing part-time, as needed, the services of qualified licensed pharmacists from a community pharmacy. The pharmacist practicing in the corner drug store has long been overlooked as the logical person to provide competent pharmaceutical services in the small hospital. His service to the people of his community has established him as a professional man of recognized leadership—one to whom the community looks for guidance and help.

Most important, he can accept the challenge presented to the pharmacy in a greatly expanded hospital field, and reflect credit to the entire profession. This challenge has become particularly important now that all aspects of medical care are undergoing change and transition.

The American Society of Hospital Pharmacists, at its 1953 convention in Salt Lake City, passed the following resolution:

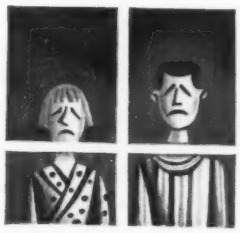
> **Resolved that the American Society of Hospital Pharmacists encourage local retail pharmacists to give pharmacy services to small hospitals which do not employ a pharmacist.**

The society and the American Pharmaceutical Association together have established the Division of Hospital Pharmacy, which serves as an information center and a co-ordinating unit for pharmacy service in hospitals, and is ready to assist the community pharmacist who wishes to use its services.

Almost any hospital, regardless of its size, will find it possible to enter into some arrangement to obtain the benefits of a competent professional pharmacist's contribution to effective hospital service.

The importance of the pharmacy in the over-all operation of an efficient hospital in terms of good patient care, economical business practices, and safety in the handling of drugs is obvious. And the efficient practice of pharmacy in a hospital can be an integral part of the institution's public relations program.

Further, we are forced to recognize that failure to furnish efficient and capable pharmaceutical service in a hospital can harm this program seriously by undermining the confidence of the community in the quality of care being given by the institution. Without a doubt, the pharmacist is not only an important part of the hospital team—he is a vital cog in the hospital public relations program as well.



HOSPITAL

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The treatment period is shortened and patients get back in stride sooner with Gantrisin, the dependable wide-spectrum sulfonamide. Beds become vacant faster in urological, medical and surgical wards.

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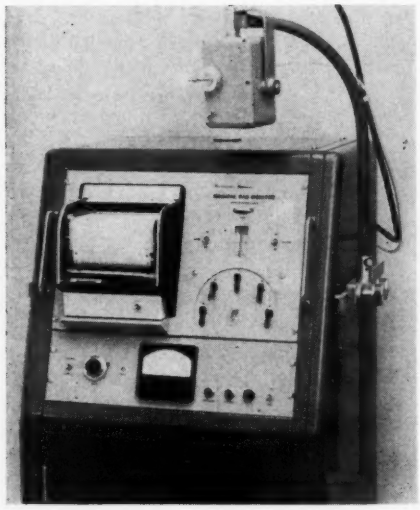
BUYER'S GUIDE

Ellen L. Davis

Buyer's Guide Editor

For further information on any of the products, please check the Buyer's Guide number on the reply card opposite page 144.



500. Medical gas monitor

Self-contained system for measuring medical gases by infrared radiation. During anesthesia, detector arm can be clamped to operating table with console being used at remote distance. Detector is pressurized for safety in explosive atmosphere. In physiological testing adjustable height of detector makes it possible to reach subject in sitting, lying, or standing position. Spinco Division, Beckman Instruments Inc., Stanford Industrial Park, Palo Alto 25, Calif.

501. Radiation warning signs

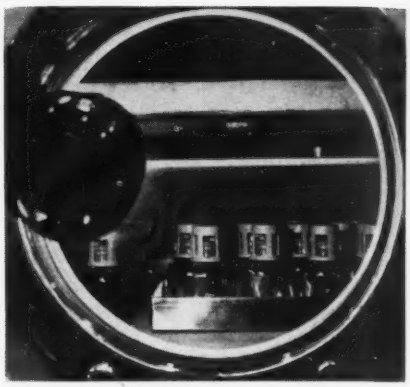
Two aluminum signs: one, marked "Caution Radiation Area," is for sections in which the radiation level exceeds 5 millirems but is less than 100 millirems per hour; the other, marked "Caution, High Radiation Area, Personnel Monitoring Required," is for areas of radiation level over 100 millirems per hour, where measuring devices must be worn. Picker X-Ray Corp., 25 Broadway, White Plains, N. Y.

502. Hand dryer

New motor design allows air to move directly to high-speed fan, after passing over heating element where it is heated to 140° F. Automatic circuit breaker prevents overheating. Vandal-proof; cleanable with damp cloth. World Dryer Corp., 616 W. Adams St., Chicago, Ill.

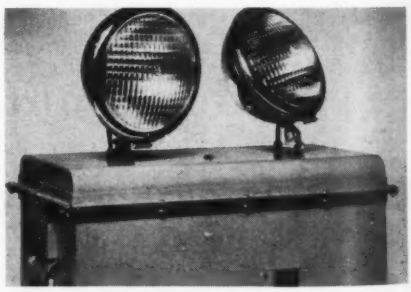
503. Air filter

New Micro-Filter for use on the Isolette infant incubator removes contaminations from hospital nursery air, helps minimize danger of air-borne infections. Forced circulation of air drawn from outside hospital provides complete isolation; continuous slight flow of air outward prevents nursery air from entering. Air-Shields, Inc., Hatboro, Pa.



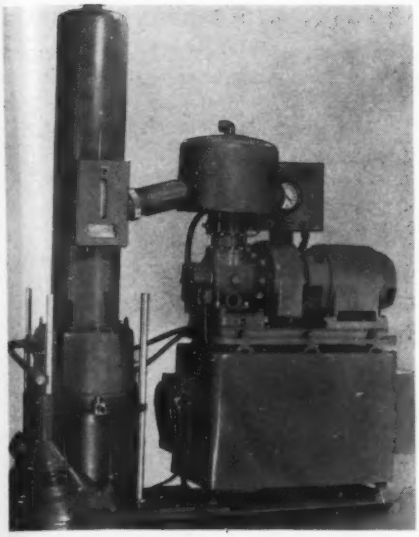
504. Stoppering device

Automatically sets stoppers into bottles or vials in which material has been freeze-dried; done while bottles are still within vacuum chamber, to prevent possible contamination once vacuum is broken. Bottles of varying heights and shapes can be processed simultaneously on different shelves; partial to full loads handled without adjustments. F. J. Stokes, Corp., 5500 Tabor Rd., Philadelphia 20, Pa.



505. Emergency light

Waterproofed for outdoor use, can also be used indoors in areas containing corrosive gases, chemicals, high moisture content, and dust, which might foul mechanism. Operates from regular 115-volt AC circuit, providing light instantly when regular source of power fails. Electric Cord Co., 21 Spruce St., New York City 38, N. Y.



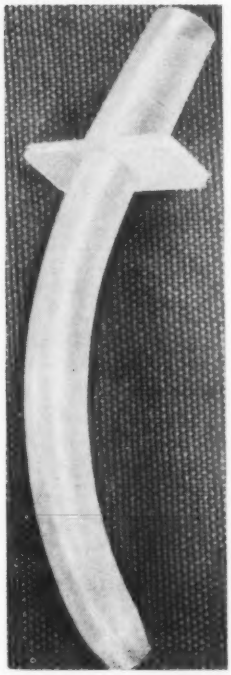
506. Liquid nitrogen generator

Packaged generator system purifies incoming air, precools it to liquid air temperature, and separates out liquid nitrogen. No moving parts for air intake or product production. Rate is approximately four quarts per hour. Can be purchased separately for converting company's existing installations, or in combination with liquid air unit to provide a complete liquid nitrogen producing plant. Instruments Division, Philips Electronics, Inc., 750 S. Fulton Ave., Mt. Vernon, N.Y.

507. Oxidase discs

Fast, economical test for presumptive identification of *Neisseria*, including pathogenic gonococcus, meningococcus, and the saprophytic species. Accurate, maintaining stability at room or refrigerator temperatures, discs eliminate daily preparation of reagent. Scientific Products, Inc., 1210 Leon Place, Evanston, Ill.

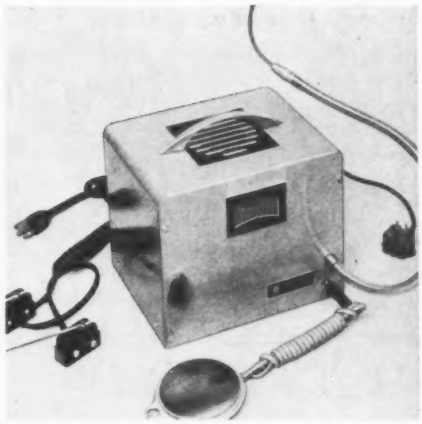
508. Connector



Fits inside tracheotomy tube, providing connection, by means of tapered fitting, to any tube and gas or oxygen equipment. Cold-sterilizable plastic, comes in 2 models to fit size 4 and size 6 Sierra-Sheldon tracheotomy tubes. Can be used for emergency induction of oxygen or anesthetic, as well as elective tracheotomy. R. A. Hawks Division, Sierra Engineering Co., 123 E. Montecito, Sierra Madre, Calif.

509. Containers

Reusable, non-toxic plastic containers, 11″ x 11″ x 2″, to maintain constant cold, in models for 3 temperatures ranging from minus 25° F. to plus 25° F. Chilled and frozen items may both be carried in same container, each at desired temperature. Kemi-Kold Corp., P.O., Box 5756, Orlando, Fla.

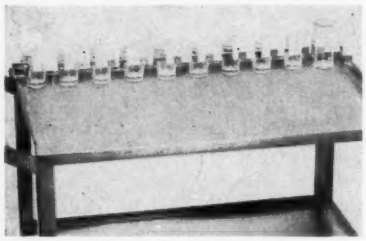


510. Rehabaphone

Rehabaphone makes telephoning possible for persons with little or no muscle power. Can be used by anyone able to press against lever of sensitive microswitch—by bulging out the cheek with tongue; by opening and closing the mouth; by flexing muscles used to clench teeth, smile, or wink; or by motion of chin, foot, hand. Operates on 110-volt AC current, fits any phone jack. Large carrying handle. Seeger-Williams, Inc., 4 Norman St., Bridgeport 5, Conn.

511. Sedentary workers' chair

Permits complete flexibility, with seat moving laterally in four directions in response to slightest body movement. Chair is claimed to sharply reduce fatigue, increase seating comfort. Legs and base frame of steel tubing with die-cast aluminum housings containing rubber bushings which give the flexibility. Seat and back upholstered in nylon-backed vinyl fabric. Seating, Inc., Robbins, N.C.



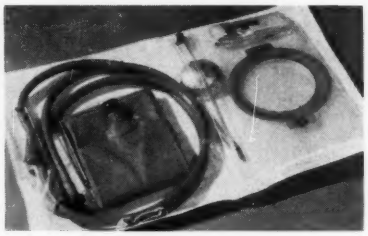
512. Utility cart snap-rack

Made to fit Lakeside utility carts, racks come in two sizes, one to accommodate 10 1-oz. medicine glasses or 2½-oz. medicine cups, the other smaller size for 1-oz. paper cups. Removable clips provided to attach identification cards on each glass. Up to 5 racks will fit on top of cart for 50 medications. Heavy gauge steel wire, chrome plated. Lumex, Inc., 9 Cleveland St., Valley Stream, N.Y.

513. Coffee urn battery

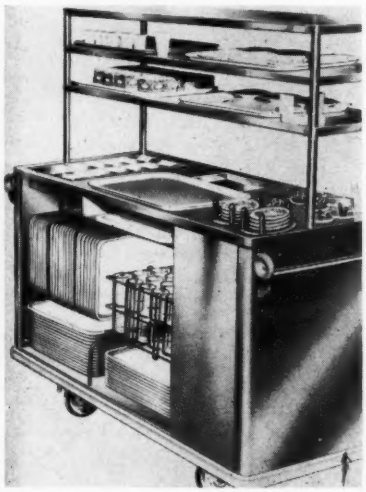
Three-piece stainless steel coffee urn battery has welded seams, paneled sides. Coffee liner front drain eliminates center connection fittings; has dial thermometer for controlled temperature, self-closing, easy-to-clean faucets. Three-gal. coffee capacity per urn; 8-gal. water boiler. Cecilware-Commodore Products Corp., 199 Lafayette St., New York City 12, N.Y.

514. Colostomy case



Extra parts of Greer Colostomy Compact now packaged in air-tight, water-proof plastic travel case large enough for entire irrigating apparatus. No charge for case with purchase of complete compact; item is low in cost when it is bought separately. John F. Greer Co., 3805 Broadway, Oakland 11, Calif.

515. Dish dispensers

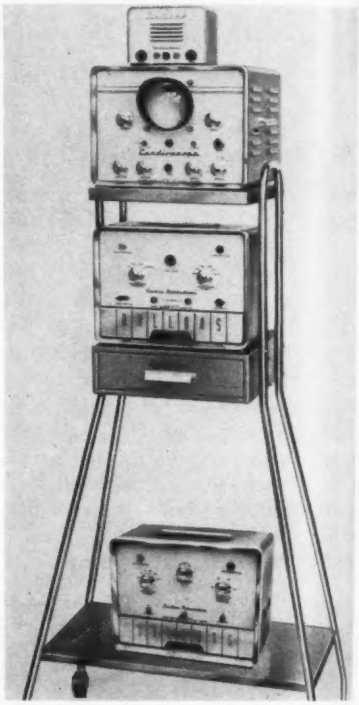


New development in Meals-on-Wheels incorporates two AMF lowerator dispensers in mobile cold assembly table. Designed to increase ease of handling butter plates and saucers when loading trays, lowerators have stainless steel coil-spring mechanisms which automatically position china at proper serving level. As each piece is used, another pops into place. Posts extending above well-edge hold top dishes in alignment for easy removal of four or more at once. Floating action of mechanism enclosed in tube insures sanitation, reduces noise in use or transit. Meals-on-Wheels System, 5001 E. 59th St., Kansas City 30, Mo.

516. Disposable slipper

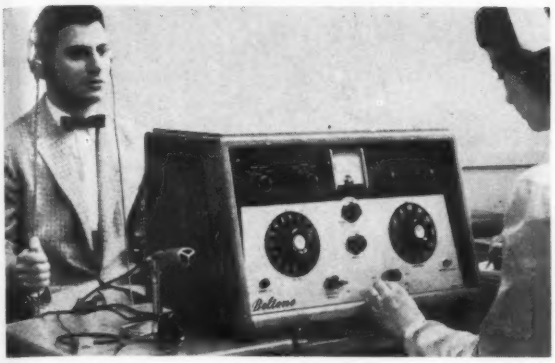
Creped wet-strength kraft paper, plastic coated for toughness. With seams automatically heat-sealed to resist pressure and moisture, slippers can be worn in shower without disintegrating. Contour-shaped for natural walking. Gilbert Manufacturing Co., 200 W. 24th St., Hialeah, Fla.

517. Cardiology set



Seven-piece matched equipment includes 1) diagnostic electro cardioscope for continuous monitoring of electrical potentials of heart; 2) variable-tone cardiophone for audible interpretation; 3) defibrillator to stop ventricular fibrillation; 4) pacemaker to induce muscular contraction at any given rate for any length of time; 5) electro cardiotone which produces audible pulse tones and indicates variations on easily read meter; 6) temperature monitor for continuous measurement of esophageal, dermal or sub-dermal temperatures during hypothermia; 7) EEG amplifier to portray, on cardioscope screen, depth of anesthesia as measured by recorded activity of alpha waves of the brain. Dallons Laboratories, Inc., 5066 Santa Monica Blvd., Los Angeles 29, Calif.

518. Diagnostic audiometer

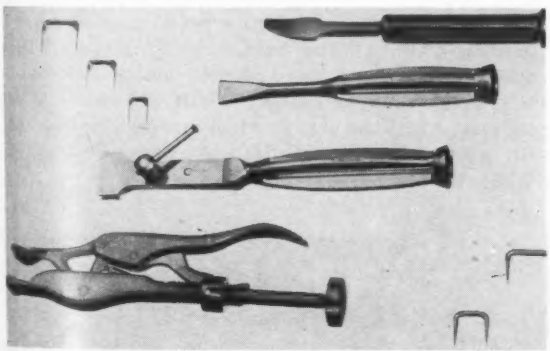


Featuring transistorized speech circuit and simplified loudness balance control, audiometer gives accurate loudness balance in aural recruitment tests. A 1,000-cycle tone at 50 decibals may be presented in one ear while the same tone at another intensity is presented in other ear alternately without dial turning. Seventeen different types of speech and pure tone hearing tests can be conducted. Weighs 28 lbs., is 21½" long, 13¼" high, and 13¾" deep. Beltone Hearing Aid Co., 2900 W. 36th St., Chicago, Ill.

519. Surgical dressing

Employing rayon instead of cotton, new surgical dressing has closer weave which prevents invasion by capillary buds with consequent painful and damaging adhesion of dressing to wound. Permits adequate drainage through mesh; can be sterilized by autoclaving. Surgical Products Division, American Cyanamid Co., 30 Rockefeller Plaza, New York City 30, N.Y.

520. Staple instruments



Instruments for use with Vitallium fracture and epiphyseal staples are, from upper right: Blount staple extractor, Blount staple set instrument, staple inserter, and Vise-Grip staple inserter. Top 3 have Kool-Grip handles for quick-cooling, balance, nonslip grip; any may be used with Vitallium epiphyseal staples (upper left) and Vitallium fracture staples (lower right). Austenal, Inc., Surgical Division, 224 E. 39th St., New York City 16, N.Y.

521. Laboratory cleaner

Coleo, specially formulated product for hospital, clinical, and medical laboratories, cleans all kinds of glassware, instruments, rubber, plastic, and enamelware, is especially effective for blood removal. Dissolves readily, rinses freely. Wetting and penetrating agent for fast action. In 5-lb. cans (6 to the case) or 50- and 100-lb. drums. Associated Products Department, Colgate-Palmolive Co., 300 Park Ave., New York City 22, N.Y.

522. Automatic film processor

Medi-Matic 16, for use in conjunction with cine radiography, is designed for leaderless self-feeding—no darkroom required. Fully adjustable speed and temperature controls permit selection of best processing technics. Prior knowledge of film processing or chemicals unnecessary as packaged developers can be added to the 3 chemical tanks once daily. Tanks are removed with a turn of a wing nut, are easily rinsed at night. One loading is sufficient for processing 400 feet of film. Normal processing speed is 2 feet per minute. As soon as film emerges completely dry it may be inspected, then speed control varied to improve degree of contrast. Film lengths from 1 to 400 ft. can be processed at one time. Portable. Industrial Camera Division, Fairchild Camera and Instrument Corp., Robbins Lane, Suosett, L.I. N.Y.

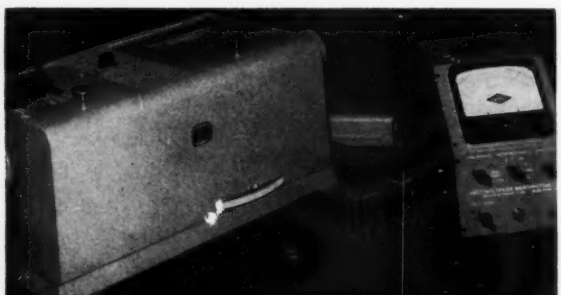
523. New biopsy instrument

Truelove-Salt biopsy instrument is designed for use in even the most severe cases of ulcerative colitis and amoebic dysentery, is claimed to be the only instrument for this purpose which precludes the danger of bleeding. Repeated biopsies for histological follow-up can be taken without danger. E. Miltenberg, Inc., 43 Great Jones St., New York City 12, N.Y.

524. Hammock folding wheel chair

Chair seat and back of saddle-grained plastic leather reinforced with heavy duck canvas; foam-padded arm and leg rests. Lightweight footboards, with safety tread, and adjustable leg rests can be interchanged without tools—snap and lock into place via push-button control. Folding leg rests adjust to any angle. Positive locking brakes on both wheels, stainless steel clothing guards. Also available in proportioned juvenile model. Colson Corp., Jonesboro, Ark.

525. Light-scattering photometer



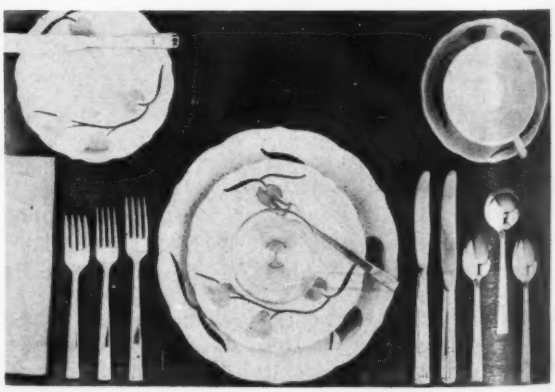
Applications include blood-specificity studies; radiation effects on nucleic acid, proteins, other biological materials; measurement of aerosols droplet sizes, of contamination of fuels and hydraulic acids, of atmospheric impurities for control purposes. Operates by passing a light beam of uniform radiation through sample in solution. Resulting light-scattering is measured, applied to known values for proper evaluation. American Instrument Co., 8030 Georgia Ave., Silver Spring, Md.

526. Visual-auditory heart monitor

Small microphone clamped over palmar surface of last phalanx of any finger or toe picks up digital pulse, relays it to main unit where it is registered by flashing red light and clicking noise synchronous with pulse. Pulse irregularities immediately noticeable. Portable, the unit is well sealed, the circuit being made and broken only when turned on and off. Safe to use in presence of explosive gases. Designed primarily for the operating room, it adapts to post-anesthesia recovery rooms, delivery rooms and constant care wards. Useful in pre- and postoperative preservation and evaluation of peripheral blood flow in vascular disease. Allen Electric and Equipment Co., Kalamazoo, Mich.

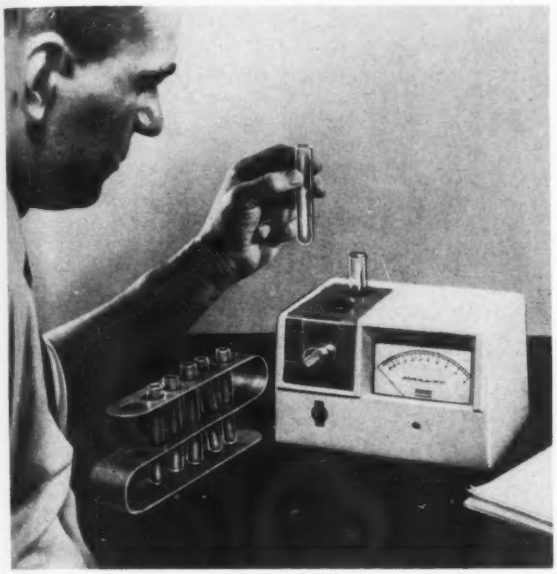
527. China place setting

One of 23 open stock patterns especially designed for use in institutions and public eating places, Patio pattern has stylized, hand-painted yellow leaves on black stems. Translucent, true vitrified china, it is detergent and dishwasher proof, cannot be scratched with ordinary table knife. Syracuse China Corp., 1800 W. Fayette St., Syracuse, N.Y.



528. Portable floor lamp

For patient room lighting, lamp has adjustable height range of 5½ in. for variable height beds. Reflector dome has no connection to wires, rotates freely to direct light; movable bulb shield for direct-indirect lighting. Cool operation, high light output. Low center of gravity assures practically tip-proof performance. Kurt Versen, Inc., Englewood, N.J.



529. Direct-reading hemophotometer

For determining hemoglobin by the Drabkin cyanmethemoglobin method. Blood sample is diluted with Drabkin's solution and placed in a cuvet. Latter is placed in the well of the instrument and the hemoglobin content per 100 ml. of blood is immediately readable. To reduce effects of voltage variations, machine has regulator that transforms 115-volt AC current into a 6.3-volt power supply for the lamp; two-photocell system eliminates effects of fluctuations in intensity of light source. Fisher Scientific Co., 717 Forbes St., Pittsburgh 19, Pa.

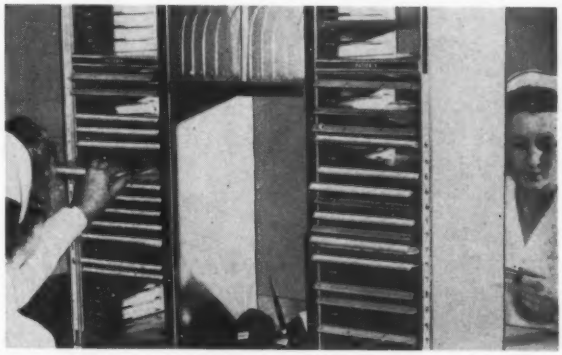
530. Fluorescent lamp guard

Designed for new slimline fluorescent tubes, guard avoids personal injury from falling tubes and damage to material, machinery, food mixes, other merchandise. Installed quickly, permanently, with screwdriver. Specially treated resilient steel makes it possible for guards to be sprung aside for relamping and cleaning. Den-El Equipment Co., 21 Spruce St., New York City 38.

531. Nurse call system

Audible-visible call system with completely transistorized amplifier. Conventional telephone handpiece replaces talk-listen switch. Requires only two wires common to all rooms and one individual wire to each patient outlet, making possible use of present wiring in 80 percent of hospitals. Requires no warm-up time; can be placed at "off" when not in use, eliminating frequent tube replacement. Royal Communication Systems, Inc., 2130 W. 110th St., Cleveland 2, O.

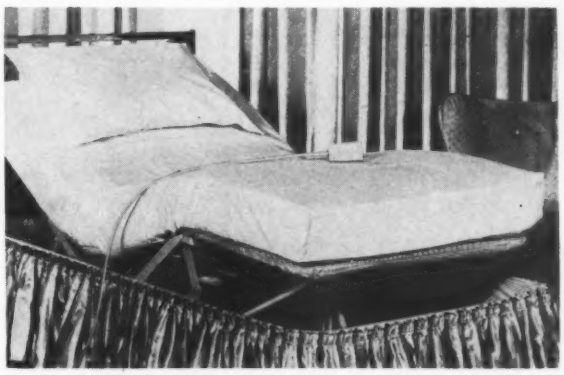
532. Two-way chart file system



Adaptable to large or small operation, system eliminates confusion through placement of charts in allocated sections of rack. Four persons, two on each side, can work simultaneously. Chart identification slips at both ends of holders; self centering charts within easy reach; transparent plastic pocket for admission slips attached inside chart holder. In 30- and 40-chart capacity. Heavy gauge furniture steel finished in baked enamel, aluminum trim. Shampaine Co., 1920 S. Jefferson Ave., St. Louis 4, Mo.

533. Stain-resistant wall covering

Fabrique, combining style and color of wallpaper, wipe-clean features of paint and vinyl, is 100% textile fibres, vinyl impregnated. Soap and water remove lipstick, crayon marks, coffee, ink, ketchup, jelly; facial tissue removes grease. Non-woven, it has equal tensile strength in all directions, does not have to be lapped; covers bumps; elasticity adjusts to humidity and temperature changes. Birge Co., 390 Niagara St., Buffalo 5, N.Y.



534. Bed lift power unit

Sold as part of an adjustable bed or as an installation for beds already in use in hospitals, power lift eliminates manual cranking. A 4-button hand switch allows patient or nurse to maneuver bed into one of many positions, with special valve in each hydraulic cylinder locking spring into place. Head and foot movement controlled separately. Fits any standard hospital gatch spring; electrical connections and components encased in fireproof fiber glass insulation. Detroit Harvester Co., Detroit, Mich.

FILMS, NEW LITERATURE

540. Safety codes

New 42-page *F.E.M.A. Handbook of Safety Codes* outlines the various procedures for maintaining, protecting, recharging and inspecting fire extinguishing equipment commonly used in hospitals. Both mandatory and recommended procedures for assuring long life and efficient service from portable fire extinguishers, carbon dioxide systems, standpipe and inside hose systems, and fixed foam systems are also presented. Fire Equipment Manufacturers' Association, One Gateway Center, Pittsburgh 22, Pa.

541. Laboratory scales

Four-page brochure describes three new Shadograph laboratory balances for rapid, accurate weighing of small animals, animal tissues, chemicals, and animal diets. One balance for centrifuge cups and general laboratory weighing is also illustrated, as well as a precision automatic net weighing machine capable of accuracies to 1/10 gram. The Exact Weight Scale Co., 538 E. Town St., Columbus 15, Ohio.

542. Monomers-Polymers

A 1958 catalog, listing more than 500 monomers and polymers, has been released for research chemists. It includes many new cross-linking agents, monomers for poly-electrolytes, and substituted ethylenimines. Monomer-Polymer Laboratories, The Borden Chemical Co., 5000 Langdon St., Philadelphia 24, Pa.

543. Iodophor germicide

Ioclide, new concentrated iodophor germicide, is discussed in a 32-page brochure. Its exact nature, its uses as a fast-killing germicide for the disinfection of general medical instruments and materials, its effectiveness as a pre-surgical scrubbing agent, and recommended procedures for disinfecting contaminated surgical and hospital instruments are reviewed. Laboratory Reports Department, Clay-Adams, Inc., 141 E. 25th St., New York 10, N.Y.

544. Acoustical tile

Complete application specifications for *Styltone,* a fissured, non-combustible, mineral wool acoustical tile are presented in an illustrated data sheet. Included are a complete list of materials, directions and specifications for the three most common methods of acoustical tile installation — adhesive, concealed suspension, and exposed suspension. Acoustical Products Division, Baldwin-Hill Co., Breunig Ave., Trenton 2, N. J.

545. Buccal Varidase

The physiology and medical applications of the buccal use of Varidase, streptokinase — streptodornase, are outlined in a new 25-minute color film. Also covered are actual clinical cases where the drug, effective in the management of inflammation and swelling associated with trauma or infection, was used, including a severe burn case, a carcinoma of the lip, diabetic ulcers, carbuncles, and a thrombophlebitis. Lederle Laboratories Division, American Cyanamid Co., Pearl River, N. Y.

546. Prostate surgery

Retropubic prostatovesiculectomy is the subject of a new film which demonstrates the operative procedure, on a cadaver, in meticulous detail, and points out the advantages of the retropubic approach— particularly the excellent surgical exposure it affords. Eaton Laboratories, Norwich, N. Y.

547. Antimicrobial agents

A wall chart giving up-to-date listing of antimicrobial agents by both generic and trade names with their manufacturers and microbial derivation is designed to help laboratory personnel with the complex nomenclature often associated with the newer agents. Glossy stock, 21¾ in. long by 17 in. wide. Baltimore Biological Laboratory, Inc., division of Becton, Dickinson and Co., Rutherford, N. J.

548. Binary scaler

Model BS-512, new NMC binary scaler for use with medical isotope systems, is described in two-page bulletin. Scaler has seven scale selections, ranging from 8 to 512; high voltage supply; single stroke reset mechanism; automatic control of counting periods; and ability to register 5 million counts per minute. Data is also included on five other NMC radiation detection, measurement, and recording instruments for clinical, research, and industrial use. Nuclear Measurements Corp., 2460 N. Arlington Ave., Indianapolis 18, Ind.

549. Psychiatric nursing

Psychiatric Nursing: The Nurse-Patient Relationship, new film for teaching graduate nurses and orienting student nurses, is available for short-term loan. In following the frustrations as well as the achievements of a nurse in a typical state hospital situation, the film reviews many of the basic technics in psychiatric nursing. Available from Smith, Kline & French Laboratories, Philadelphia 1, Pa., or ANA-NLN Film Library, 267 W. 26th St., New York 1, N.Y.

550. Centrifugal fans

Four new airfoil-type centrifugal fans, which increase the capacity range of Ilg's BC airfoil centrifugal fan line to 55,152 c.f.m., are described in Bulletin 257-S. Information is included on all the varieties of speed control on both direct-connected or belt-driven models, plus construction data, specifications, and capacity tables. Ilg Electric Ventilating Co., 2850 N. Pulaski Rd., Chicago 41, Ill.

551. Surgical procedures

New Surgical Procedures, dealing with the subject "Surgical Closure of the Incompetent Cervix During Pregnancy," is the second of a series of folders. Illustrated text, in fold-out form, is designed as a teaching aid and reference source. Ethicon, Inc., Somerville, N.J.

552. Electron microscope

Six-page folder contains engineering information on the Norelco EM-100B electron microscope. Text covers construction details, electron optical system, electron source, condenser lens, objective lens, and intermediate lens system. Illustrated with cross-sectional drawings. Instruments Division, Philips Electronics, Inc., 750 S. Fulton Ave., Mount Vernon, N. Y.

553. Paper products

A new catalog, including a number of new additions to their line of disposable paper products, has been issued by the Pro-Tex-Mor Medical Division of Central States Paper and Bag Co., 5221 Natural Bridge, St. Louis 15, Mo.

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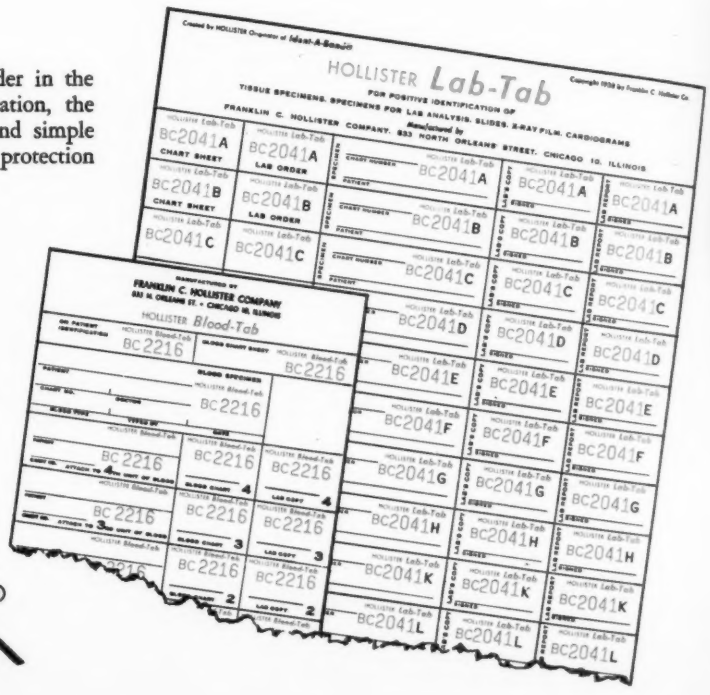

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TOPICS Spotlights AHA Exhibits

It was the hospital field's big show of the year—the annual convention of the American Hospital Association, held at the International Amphitheatre, Chicago, August 18-21. The more than 400 exhibiting firms sent approximately 3,500 representatives to staff their booths. Some of the newest products featured are shown in this special section. Additional product news pictures will appear in the October issue.

All photos by HOSPITAL TOPICS

Above: New intermittent vacuum regulator for oxygen flow operates from wall outlet or pump on 120-90 mm. of mercury. It has a positive-float, controlled shut-off valve. J. J. O'Donnell (r.), National Cylinder Gas division of Chemetron Corp., explains unit's operation to Samuel H. Franks, manager, VA Hospital, Oakland, Calif. C-560

Right: Helene I. Tadowsky, R.N., chief, nursing service, VA Hospital, Erie, Pa., gets details from Douglas M. Fish on the mattress and bedding disinfector just introduced by the American Sterilizer Co. Mattress and bedding are subjected to four hours' exposure to ethylene oxide. C-561

Left: Elsbeth McClure, vice-president, Women's Auxiliary, Jones Memorial Hospital, Wellsville, N. Y., discusses patterns in Amtico rubber and vinyl floorings with Charles Ballanz, representative of American Biltrite Rubber Co.'s Amtico Flooring division. Featured at exhibit was Amtico conductive vinyl tile which is germ-proofed with Permachem, a permanent antiseptic. C-562

Below: Portable cassette holder is demonstrated by J. Don Richards, Richards Mfg. Co., Inc., for E. F. Saunders, administrator, Massena (N.Y.) Memorial Hospital. Ball and socket arm will adjust to any position; height can also be adjusted easily. Holder is quickly locked in position or released with T handle. C-563

Left: Explaining action of Sim-Matic motorized hospital bed is V. J. McInery (r.), Simmons Co. David Burack (l.), purchasing agent, Mount Sinai Hospital, Hartford, Conn., and Isidore S. Getter, M.D., director of the hospital, watch demonstration of bed's portable control switch which raises and lowers bed, will also raise and lower head and foot sections separately. Also featured at booth was motorized Vari-Hite bed. C-564

Left: Anti-staphylococcal action of Albamycin, Upjohn antibiotic, is subject under discussion by Ed W. Nemity (l.), administrator, Community Hospital, Kingfisher, Okla., and H. F. Layson, Upjohn Co. representative. Sterile sponges, gauze, and powder, and Gelfoam sponges were part of company's co-ordinated display emphasizing infection control. C-565

Above: Sister Maria of Providence (center), St. Luke's Hospital, St. Louis, Mo., and Sister Joseph Albert, maternity supervisor, Lewis Memorial Maternity Hospital, Chicago, stop to view the new Hard Converta-bed, demonstrated by Bob Horan, Hard Mfg. Co. Adaptations allow six different uses for same bed. Removal of head or foot pieces enables use as eye, fracture, or orthopedic bed; addition of knee crutches makes delivery bed, side fittings, a recovery bed. Can be used as regular room bed. C-566

Above: Deknatel Plastic Pak is shown by Fran Glynn to Mother Eugenia and Mother Angela, both from the Frank Cuneo Memorial Hospital, Chicago. Deknatel surgical gut is hermetically sealed in the transparent pack, which is opened by cutting straight across. Suture slips out easily when pack is inverted. C-568

Right: Featuring products to aid in comprehensive hospital sanitation program, Klenzade Products, Inc. booth highlighted methods of combatting hospital infections. Here John McKillop, Klenzade, tells Mrs. Sam Sullivan (l.), vice-president, and Mrs. E. H. Borchers, president, Women's Auxiliary, Mercy Hospital, Laredo, Tex., about Ster-Kleen, organic acid detergent for mineral deposit control. Cleaner is recommended for alternate use program with Med-I-Kleen, synthetic detergent formulation for general medical cleaning. C-567

Right: Travenol disposable twin coil artificial kidney attracts the attention of Erwin Remboldt (l.), administrator, White Memorial Hospital, Los Angeles. Sherwood Hall, representative, Baxter Laboratories, Inc., explains operation of dialyzing unit and shows how it is connected to patient. Back curtain of exhibit is constructed of cellulose tubing enveloped in fiberglass screen, which is material used for the disposable coil in the dialyzer. C-569

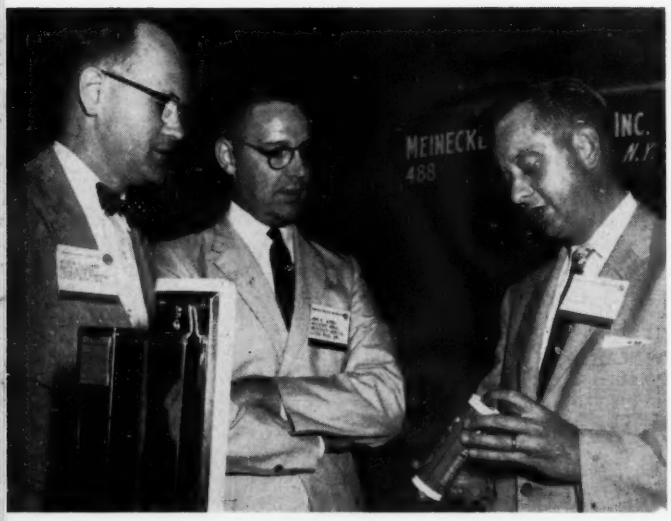
Above: New Aloe progressive care patient valette is demonstrated by Charles Kanter (l.), A. S. Aloe Co., to Robert D. Southwick, administrator, Children's Hospital, Cincinnati, O., and Vernon C. Stutzman (r.), director, Methodist Hospital, Brooklyn, N. Y. Unit combines clothes closet, dresser, and bedside cabinet, allowing quick, easy movement of patient. C-570

Above: Virginia Jauch, nutritionist, Chicago Board of Health, discusses vitamin solutions with S. H. Severson, Abbott Laboratories. He is demonstrating use of Abbott disposable I. V. equipment for administration of company's prepared intravenous solutions, which include analgesic solutions, balanced fluids for electrolyte replacement therapy, and nutritional additives. C-571

Left: Charles L. Showalter (l.), administrator, Memorial Hospital, Charleston, W. Va., talks to Michael Fisher, Debs Hospital Supplies, Inc., about PKS, Debs' complete patient card system. Designed for use at patient's bedside, system includes self-adhering instruction plaque, preprinted instruction cards with space for patient's name and room number, and dispensing rack. Cards are two inches by four inches, are color-coded according to type of instruction. C-572

Below, left: At Meinecke & Co., Inc., booth, Nelson F. Evans (l.), administrator, and John W. Gerdes, assistant administrator, University Hospital, Little Rock, Ark., watch Paul Murray (r.), Meinecke, demonstrate pliability of plastic container-dispenser for T.L.C., medicated lotion for massage and skin care. Lotion contains silicone and hexachlorophene, protects, softens, and refreshes the skin. Container is designed for convenience in hospital use, provides space for writing in patient's name and room number. C-573

Below, right: Glen Lauth (l.), administrative assistant, Lutheran Hospital, Moline, Ill., tests balance of Hypak sterile, disposable syringe-needle combination, demonstrated by R. Orvetz, Becton, Dickinson & Co. Barrel of syringe is all glass to avoid solvent action by parenteral fluids. Sharper needle point has been developed for one-time use, to increase patient comfort. C-574



Above: Helen H. Borst, laboratory technician, St. Mary's Hospital, Madison, Wis., feels texture of disposable drape held by Joseph R. Howard, representative of the Ruby Products Co., Inc., which featured its obstetrical Surg-O-Pak at the exhibit. Completely disposable, the pack contains drapes, basins, sponges, vaginal packings, all other accessories required for delivery. C-575

Above: Ezon, new, noninflammatory, micropulverized glove dusting powder, is center of interest for (from left) Bob Knowles and Stan Pask, both of Seamless Rubber Co., David Johnson, assistant director, Miami Valley Hospital, Dayton, O., and Phyllis Hitzemann, administrator, Doctors Hospital, Omaha, Nebr. Modified starch powder was developed for surgeons' gloves. C-578

Right: Arthur S. Malasto (l.), administrator, Porter Memorial Hospital, Valparaiso, Ind., listens attentively as Robert K. Fisher, representative, Gomco Surgical Mfg. Corp. explains the workings of the No. 766 thoracic thermotic pump, developed to provide suction in a volume sufficient for chest surgery. Clock mechanism automatically creates an alternating expansion and vacuum process which makes the pump function. The cycle is repeated eight times a minute, but suction remains relatively constant. The device, which operates on 115-volt, 60-cycle current, is designed so that greater portion can be pushed under patient's bed. C-576

Below: Sonogen Model 50 ultrasonic cleaner is shown by R. Hollerith (l.), Branson Ultrasonic Corp. representative, to Cary Edge, administrative officer, U. S. Naval Hospital, Newport, R. I. Stainless steel cabinet houses ultrasonic generator and cleaning tank, and rinse tank. Both tanks have hot and cold water faucets, drains, and removable lids. Spray rinse and air blow-off facilitate rinsing and drying surgical instruments, syringes, needles, and glassware. Controls, located on sloping back panel, include power switches, tuning control, line voltage adjustment; temperature control may be installed. C-577

Below: New bedside control center, an integrated, self-help patient care facility, drew many interested observers to Minneapolis-Honeywell Regulator Co. exhibit. Here Clifton H. Linville (center), administrator, Fresno (Calif.) Community Hospital, and Philip A. Austin, Washington State Department of Health, Seattle, watch model demonstrate how patient, by fingertip adjustment from bed, can control room temperature and lighting, bed height and position, draperies, radio and television, and new type of automatic telephone with dial built into speaking-hearing unit. C-579

Above: New hammock-style folding wheel chair, featured at the Colson Corp.'s display, is shown by C. C. Cage, Colson, to Hazelann R. Tateosian, R.N. (l.), nurse anesthetist, Bethesda Hospital, St. Paul, Minn., and Beverly Fillips, R.N., nurse anesthetist, Fairview Hospital, Minneapolis. Chair has full-size seat and back, in saddle-grain upholstering; foam-rubber arm rests; safety brakes; safety tread footboards. Folds to 9¼" width. C-580

Above: Marvin E. Yount, Jr., administrator, Alamance General Hospital, Burlington, N. C., stops to learn about the Baylor bedside cabinet displayed by E. W. Bangs, American Hospital Supply Co. Unit combines sink with storage space beneath; side panel has hook-on dial phone, clock, nurse call buttons, connections for radio and TV tuning control. C-581

Left: Jean Grabiner, Wallich Laboratories, explains use of Wallich stencil pad to Arthur Hartfelder, business manager, Evanston (Ill.) Hospital. Pad is used for printing patients' names on doctors' orders at nursing stations. Stencil is cut on a typewriter or by a stylus, then attached to pad with pressure-sensitive adhesive on rim of stencil. C-582

Below: Weck glove wraps, designed to keep gloves in proper position during sterilization, transportation, and opening wrap for use, are shown by George Ahearn (l.) and Joe Sattler (second from r.), Edward Weck & Co., Inc., to Clara C. Schilling, purchasing agent, St. Francis General Hospital, Pittsburgh, Pa., and John P. Dowling, director, Milton (Mass.) Hospital and Convalescent Home. Wraps are reusable and may be used with either Weckink sterilizing bags or outer muslin wraps. C-584

Below: One of the biggest attractions in the exhibit area was the new Stryker CircOlectric bed, which was featured in booths of three companies. Patient can be placed in a variety of positions, including sitting and standing, by rotation of the circular frame. Edward M. Grapp (r.), purchasing agent, Miners Memorial Hospital Association, Williamson, W. Va., watches demonstration by Gene Neale (l.) and Paul Remaley, Zimmer Mfg. Co. C-583

Above: J. H. Murray, Johnson & Johnson representative, gets in the middle to demonstrate how the company told its story, by phone, to convention-goers. Also listening in on the facts about sterile, nonadhering Patient-Ready dressings are Minnie P. Shuey, R.N., Fairview Hospital, LaPorte, Ind. (l.), and Jeanne Sheperd, R.N., who does surgical floor duty at the same hospital. C-588

Above: James R. Arnhart, administrator, Rutherford Hospital, Murfreesboro, Tenn., listens to Dale H. Ballard, Deseret Pharmaceutical Co. representative, explain the new Deseret Intracath—disposable unit which places a soft, pliant plastic catheter within vein with same ease as venipuncture. Incision is unnecessary, and patient may be sleeping or ambulating while infusions continue. C-585

Right: Pocket-size doctors' bag, holding 24 or more instruments and medications, is displayed by Ad Rorin (r.), Grant Co., to Edwin F. Saunders, administrator, Massena (N.Y.) Memorial Hospital. Leather zipper case measures 5"x4½"x¾"; case with contents weighs only 13½ oz. C-586

Below: Charles Butterworth, representative of Standard Electric Time Co., describes the company's Nurse Saver System to Sister Virginia Mary, pediatric supervisor, St. Francis General Hospital, Pittsburgh, Pa., and Sister Mary Henry, clinical instructor, Newcastle (Pa.) Hospital. Two-way nurse-patient intercom has automatic selection and resetting. C-587

Below: Rose Fulford, x-ray supervisor, Fairview Hospital, LaPorte, Ind., tests the at-home comfort of the new Mid-Hite bed by Huntington Furniture Corp. Looking on are Alice J. Lucas, student practical nurse, Purdue University Center, Hammond, Ind.; S. L. Thompson, company representative; and Lucille Bryan, licensed practical nurse at Fairview Hospital. Eliminating the high-low positions requiring cranking, new bed maintains accustomed medium position; patient needs no footstool. One-piece over-bed table has rubber casters which adhere to floor when pressure is exerted, to help prevent patient from falling when leaving bed. C-589

Above: Capt. Hubert P. Kirkel, USAF (MSC), School of Aviation Medicine, Gunter AFB, Ala., examines application of the Aquamatic K-pad at the exhibit of Gorman-Rupp Industries, Inc. Pad is designed for use in place of hot-water bottle or ice bag, to provide controlled heat or cooling. Sealed tubing carries circulating water at controlled temperatures. C-590

Below: Use of Hausted's new safety side bed rails is demonstrated by Everette Erskine, Hausted Mfg. Co., for Sister M. Clarence, R.N., nurse anesthetist, Mercy Hospital, Altoona, Pa. Company says rail, in ¾ length, can be adapted to 90 percent of hospital beds; can be installed without drilling holes or altering bed structure. Cross-extension turnbuckles connect rails under bed. C-594

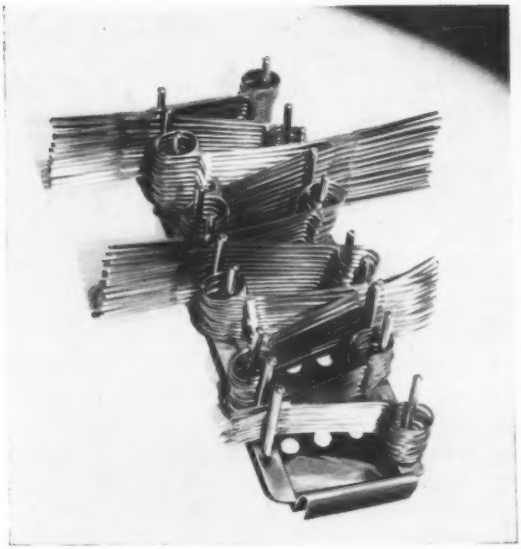
Above: Minims, sterile, buffered ophthalmic drops in individual disposable units, were featured by Barnes-Hind Ophthalmic Products, Inc. Jack Owens (r.) explains advantages of unit to George K. Hendrix, administrator, Memorial Hospital, Springfield, Ill. C-591

Left: Disposable latex surgical gloves, introduced by Perry Rubber Co., are shown by E. A. Adelman, sales manager, to Louis C. Kolenda, administrator, American-British Cowdray Hospital, Mexico City. Gloves are supplied in packages ready for autoclaving, with autoclave-indicator tape on package and packet of glove powder in cuff. Sizes 6 to 9, in white or brown latex. C-592

Below: Douglas Devendorf, VA Hospital, Washington, D.C., listens as Sandy Alexander, Ritter Co., Inc., describes the company's new twin surgical lights, designed for cleanliness, ease of positioning, and controlled illumination during surgery. Surgeon adjusts own light pattern for size, from a 6 to 10-inch field, and direction with the reflector positioned at operating distance. C-593

The New KIDD Instrument Rack

Every O. R. Supervisor Has Been Waiting For!



Holds 60 to 75 artery forceps—conveniently sorted by type and size. Permits handy removal of instruments—one or several—without disturbing the others.

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Saves Space, Too! Holds maximum number of forceps in a minimum of space for rapid convenient selection during surgery.

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THE LAB

Using The Papanicolaou Test in a Private Hospital

By Beverly Schulz, MT (ASCP)*

● The Papanicolaou test is a unique test for the detection of cancer, especially early asymptomatic carcinoma of the cervix. The reliability and applicability of cytology have been confirmed by many medical authorities in published works. Much of the literature however, represents work accomplished by agencies other than private hospitals—county medical societies, university hospitals, and other research institutions; most of these studies have been supported by grants or subsidies. However, it is possible to establish a good cytologic service in a private hospital, and doing so is to the mutual benefit of patients, doctors, and the hospital.

Our experience is based on the treatment of private patients at Milwaukee Hospital, a nonprofit, private, general hospital. The patients in our series were mostly of moderate circumstances. Almost all of the smears obtained from these patients were nonselective; that is they were taken as a routine part of the physical examination. The smears were taken from prepartum and postpartum patients; women with postmenopausal or other gynecological problems; women interested only in a routine checkup; and women with symptoms. For this reason, we feel that any statistical data derived from our service represent what can be expected in a cytology service in a general hospital, and represent also, what can be expected in terms of percentage of cancer cases detected.

The cytology program at Milwaukee Hospital was begun in 1949 by the hospital pathologist, Edward A. Birge, M.D. During the following five years, the program grew so large that it could not be handled by Dr. Birge and his associate. When this happened, I took training in cytology, and now do practically all of the cytological screening and evaluation, subject to the pathologists' review. I am also responsible for such clerical duties as follow-ups, and indexing.

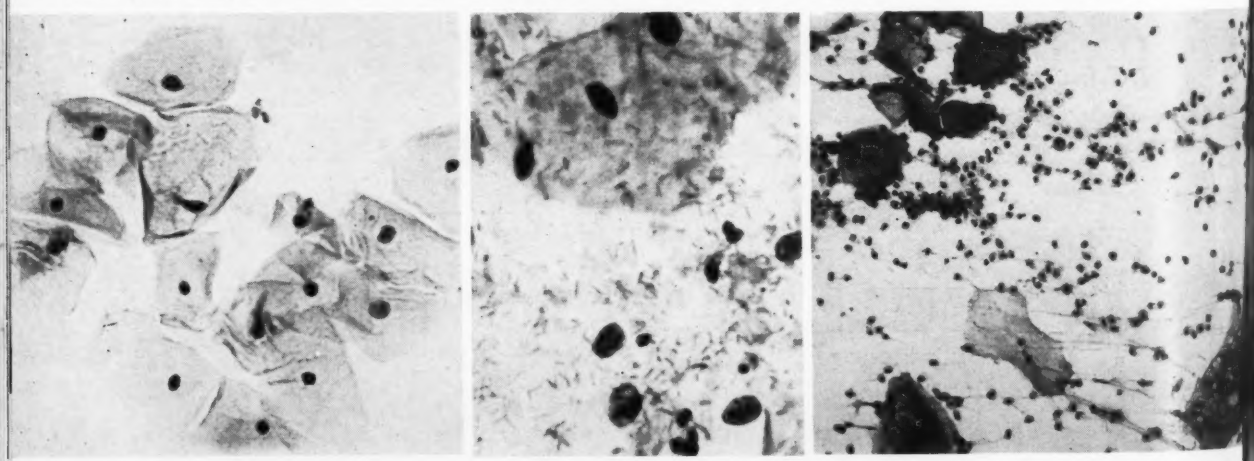
To explain our program properly, a preliminary review of exfoliative cytology is necessary.

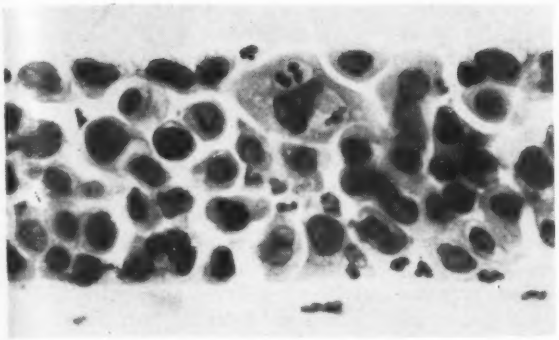
Cytology can be defined generally as the study of cells shed by tissues. Exfoliation is a fundamental, natural, normal process by which mature cells are shed from a tissue surface. The most familiar example is the shedding of cells by the skin and by the mucous membranes lining body cavities. Exfoliation occurs in normal tissue in an orderly fashion.

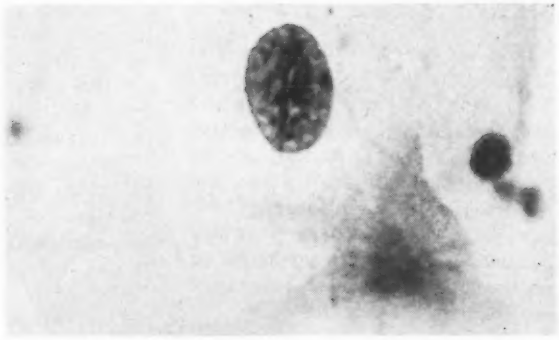
Exfoliation also occurs in abnormal tissues, including cancerous ones. Since there is no uniformity of growth in cancer, the exfoliation contains the abnormal, bi-

*Instructor in histotechnic and cytology, Milwaukee (Wis.) Hospital. This article is adapted from a lecture given by Miss Schulz at the 1958 Tri-State Hospital Assembly.

Papanicolaou smears of exfoliated cells show: (left picture) normal superficial squamous cells; (center picture) trichomonads, which cause cell changes when present in vaginal fluids; (right picture) radiation changes in benign squamous cells.







Above, left: Smear shows malignant cells from squamous cell carcinoma of the cervix. Above, right: Smear used in endocrinological studies for determination of chromosomal sex shows sex chromatin body adjacent to nuclear membrane.

zarre cells which are peculiar to the disease.

In 1928, G. N. Papanicolaou, M.D., reported finding abnormal cells, purportedly tumor cells, in smears from the vaginal secretions of women with known cancer of the uterus. Through refinements in the technic he developed for studying these smears, he proved without question a concept known for over 100 years, that is, that tumor cells are exfoliated and, with proper examination, are identifiable.

——SIGNIFICANCE CONFIRMED

There still remained the prodigious task of proving that this method of cell examination would be dependable, useful, and practical. After exhaustive study, Dr. Papanicolaou and H. F. Traut, M.D., published[4], in 1943, their unparalleled monograph on the diagnosis of cervical carcinoma by the study of exfoliated cells in vaginal secretions. The clinical significance of their work has since been confirmed by numerous investigators.

Since the initial work of Dr. Papanicolaou, the application of the technic he developed has been broadened. Now it includes the study of cells found not only in vaginal secretions but also in material from the surface of the uterine cervix, in sputum, in bronchial aspirates, in breast secretions, in fluid from pleural and peritoneal spaces, and such fluids as urine, colonic washings, gastric washings, and other exudates or transudates with lesser utility. At Milwaukee Hospital we have been concerned primarily with cervical and vaginal smears, however.

Vaginal smears are obtained by inserting a pipette into the vagina and aspirating fluid. This fluid is placed on a slide, smeared, and fixed while wet. Proper fixation is the most important part of the procedure because it preserves the morphology of the cells. In his original work, Dr. Papanicolaou advocated using a solution composed of equal parts of ether and 95 percent alcohol. Some laboratories use only 95 percent alcohol. We have found that 70% alcohol is an equally good, and less expensive, fixative.

The cervical smear is obtained by scraping the cervix gently with an Ayre spatula, a specially-shaped wooden instrument which enables the physician to scrape the ectocervix as well as a portion of the endocervix. This range is important because it is at the squamocolumnar junction that carcinoma of the cervix has its insidious beginning. Some clinicians use the tongue blade or swab for scraping.

If sputum specimens are submitted for cytological examination, they should contain material from a deep cough rather than a haphazard expectoration. The latter will probably contain only postnasal secretions, not material from the lungs. The specimen is placed directly into a wide-mouth jar containing 70 percent alcohol. The fixed sputum is subsequently smeared on a slide in the laboratory. Smears of bronchial secretions are satisfactory only when sufficient material has been obtained. These smears are also prepared in the laboratory, from the aspirated fluid.

Material for smears of breast secretions is obtained by needle aspiration or is taken directly from a nipple secretion or discharge. The slides may be prepared in the physician's offiice. If the amount of fluid is adequate, it may be sent to the laboratory for processing. Judging the wisdom of aspirating masses within the breast is beyond the province of the technician. We do examine such fluids, however, if and when they are submitted to us.

Pleural and peritoneal fluids are obtained during thoracentesis or abdominal paracentesis. The fluid is sent to the laboratory in bottles containing citrate, to prevent coagulation. When the amount of fluid is adequate, it is centrifuged first, then the smear prepared from the sediment.

When the slides are received in the laboratory for cytologic examination, they are first labeled, then stained, using Papanicolaou's OG-6-EA50 procedure. When coverslipped, the slides are ready for microscopic examination.

—MUST KNOW NORMAL CELLS

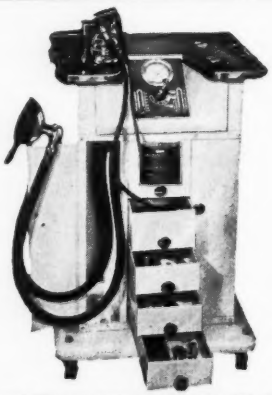
It is at this point that this "diagnostic tool" must be accurately interpreted if the presence or absence of tumor cells is to be detected. To do so, it is imperative that the technician have a well-grounded knowledge of normal cells and minor variations from normal. The latter constitutes the greatest hazard in submitting false positive or negative diagnoses. Cells which are frankly malignant or completely normal are usually so distinctive that they are not subject to false interpretation.

In interpreting vaginal or cervical smears, it is important to know the following facts. The squamous

(Continued on next page)

epithelium of the female genital tract is composed of three layers: the superficial, the transitional, and the germinal layers. In the normal female who is menstruating, or who is within the reproductive age, the superficial cells are numerous. These are the cornified and precornified squamous cells. In menopausal or postmenopausal women, the cells are exfoliated from the deeper, or transitional, layer. These are the basal cells. Cells from the germinal layer are seldom found in cervical or vaginal smears.

In identifying whether or not cells are malignant, nuclear aberrations alone are evaluated and used as criteria. Cytoplasmic changes are of secondary importance in diagnostic value. The nuclear changes seen in malignancy are: hyperchromatism, that is, deep staining qualities; clumping or coarseness of chromatin; a shift in the nuclear-cytoplasmic ratio; and the presence of large prominent nucleoli or masses within the nuclei.



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Our initial objective in utilizing the Papanicolaou smear was to detect early, asymptomatic, invasive cervical carcinoma. That we have been able, in the course of our work, to diagnose an increasing number of in situ or pre-invasive cancers, has aided the patients' chances of recovery and has been a source of deep satisfaction to us. Occasionally an endometrial carcinoma has been diagnosed by smear. However, endometrial carcinoma is a lesion which does not exfoliate readily. Moreover, cells from such a tumor are more frequently found in the vaginal pool preparations unless the lesion has extended down the endocervical canal and has involved the cervix. We have found metastatic lesions of the vagina when examining routine smears, but this is a rare occurrence. In patients with proved cancer, cells from a metastatic tumor are more likely to be found in the pleural and peritoneal effusions.

We have been able to utilize the versatility of the Papanicolaou procedure in several ways in addition to cancer detection. One such method has been the determination of the amounts, and activity, of circulating estrogens. By evaluating the character of the exfoliated cells, a rough estimate of the amounts of, and activity of, estrogen can be obtained. Smears displaying a marked estrin effect show a high degree of cornification, that is, the presence of many mature squamous cells. Absence of estrin is demonstrated in atrophic smears which contain only basal cells. This type of smear is compatible with the menopausal and postmenopausal states. It is interesting to note that in 1918 Dr. Papanicolaou, in collaboration with Ephraim Shorr, M.D., succeeded in isolating[5] the estrogenic hormone and, by using it, changed an atrophic, postmenopausal smear to the smear of a normal, menstruating female.

One of our more recent applications of the Papanicolaou test has been its use to follow the progress of patients with proved carcinoma who are being treated with x-ray, radium, or a combination of the two. The smears are examined initially to determine the patient's probable response to therapy; subsequently smears are used to diagnose recurrence as early as possible. Response to therapy may be determined because radiation produces pronounced alterations in the normal epithelial cells of the female genital tract; the most apparent changes are tremendous increase in size, vacuolization of cytoplasm, and the presence of several nuclei within a single cell. These changes will vary from one individual to another, depending upon the amount of radiation given, the time interval, and the sensitivity of the cells to ionizing radiation.

Drs. John and Ruth Graham have devised[6] an index which reflects the cellular response to this therapy. The index is called RR—Radiation Response. The index is obtained by counting 100 consecutive benign cells and determining the percentage of the cells which show radiation changes. If 75 percent or more of the cells show an RR reaction, the response to therapy is considered good and the prognosis correspondingly favorable. A response below 75 percent is considered poor and the subsequent course probably unfavorable.

——USED IN ENDOCRINOLOGY

Another of our recent uses of the Papanicolaou smear has been for determination of chromosomal sex. This has been of value in endocrinologic problems in which it is not clinically possible to be certain to which sex a patient belongs. This application involves a relatively simple determination which can be used as an adjunct in diagnosis. One hundred consecutive, well-stained vesicular nuclei with intact membranes are counted. The female pattern displays, within the nucleus, a plano-convex mass with a flattened surface. The mass lies immediately adjacent to the nuclear membrane, and it will be present in 20 to 80 percent of the nuclei. The incidence of this effect in males is less than five percent.

The last cytologic application with which we are presently concerned is the evaluation of smears for possible vaginal infections. The most frequent cause of irritation is the parasite, *Trichomonas vaginalis*. This parasite can be found in routine screening of the smears;

(Continued on page 94)

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(Continued from page 92)

no further special effort is needed to verify its presence. The only problem which may exist is that the inexperienced screener may mistake, and label as abnormal, the deceptive atypism produced in the cell when trichomonads are present in the vaginal fluid.

This reference to atypism indicates that there is a great variation between smears which are unquestionably negative or positive. This is true. To follow individuals with abnormal smears, we employ a modified Papanicolaou grading system. The smears are graded either negative, atypical, suspicious, or positive for malignancy. The negative grade is self-explanatory. An atypical smear indicates the presence of cells which are abnormal but are not considered neoplastic. In such cases, however, repeat smears are recommended within one to six months.

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In a smear graded as suspicious, it is felt that the cells are probably neoplastic. Treatment is, of course, left to the discretion of the physician but a sharp-knife conization is recommended. A smear graded as positive means the patient is considered to have carcinoma unless proved otherwise. Histologic confirmation by biopsy is considered imperative.

The cytologic service at Milwaukee Hospital was begun on a trial basis. Others had shown that such a service could be a reliable screening procedure in the detection and diagnosis of cancer. Some authorities have advocated use of such a service at intervals of six months. More recently, an interval of one year has been proposed.

The technical problems which would follow if these recommendations were universally applied to the vast number of women in the United States are overwhelming. Even if cytologic studies were made only once every 12 months, shortages of personnel, alone, would make the plan impracticable.

Most of the studies of the service which have appeared in the literature have been statistical reviews to determine the value of the technic in the diagnosis of carcinoma. In a few instances, the fate of the patient who had a negative smear initially has been studied. Weese[7] makes the statement that 206 patients in his series had two or more cytologic studies over a three and one-half year period. During his study, no patient who was initially reported as negative later developed carcinoma of the cervix. Nieburgs and his group[8] re-examined 4,482 women who had had negative Papanicolaou smears initially; 3.5 per 1,000 were subsequently found to have carcinoma in situ, after an average observation period of 25 months.

In 1957 we analyzed, and later reported at the annual meeting of the Inter-Society Cytology Council, our own statistics concerning the clinical course of patients with initially negative smears. These statistics were based on observations in 15,389 patients seen during the three-year period, 1954 through

(Continued on page 96)

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(Continued from page 94)

1956. Examinations were limited to patients with primary carcinoma of the cervix.

Approximately 65 percent of these cytologic examinations were repeat studies. The series included patients with initially abnormal smears as well as those with negative initial cytology who had returned for a routine checkup.

The unique factor in this series is that it represents a small, relatively constant segment of the population, which was studied over a period of years. Our experience, which is similar to that of many others, is that carcinoma of the cervix appears relatively early in life. In our three-year series, we observed that 45 percent of the patients with proved cervical carcinomas were 40 years of age or under; 31 percent were in the age range of 31 to 40 years.

If this observation is correct, diminishing returns could be expected from restudying the same segment of the population. We found that this appeared to be true. In 1954, 0.84 percent of the patients screened proved to have cervical carcinoma; in 1956 the percentage was 0.41, and that figure has since remained relatively constant. Table I represents a summary of our data.

Table I: Statistical Review, 1954-1956

	1954	1955	1956
Total patients	3,347	5,213	6,829
Total abnormal smears	301	423	232
Proved cervical carcinoma	28	24	29
False negatives	1	1	2

In the four false negative smears, the true diagnosis was made by biopsy within a month after the smear was obtained, since these patients had clinical evidence of cervical pathology. In the past seven years, with the exception of these four false negative smears, and one patient who had a negative smear two years before the onset of her disease, no patient with an initially negative smear has subsequently exhibited abnormal cytology; nor, to the best of our knowledge, has any patient developed a clinically evident carcinoma of the cervix.

The total period of follow-ups for all negative patients has varied from six months to two and one-half years. Conversely, the period from initial detection of abnormal cytology to final diagnosis of cancer has never exceeded 12 months. Eight patients with proved carcinoma initially had atypical smears. Within 12 months, repeat smears on these patients were graded suspicious or positive, and cervical biopsies showed carcinoma.

From a review of our statistics, it is apparent that when the same segment of the population is reexamined periodically, the number of new carcinomas of the cervix discovered by the Papanicolaou technic becomes progressively less and appears to represent the introduction of new people into the group. In our experience—in contrast to that of Nieburgs[8]—a negative Papanicolaou smear, when associated with negative physical findings in a thorough pelvic examination, indicates that the patient probably will not develop carcinoma of the cervix within a period of two years. This conclusion represents an average figure, which may increase if our patients continue to be followed. We feel that cytological examination of the cervix, when accompanied by pelvic examination, can be done at intervals of two years without risk to the patient. We also believe that such a program will not lower the current high five-year survival or cure rate for cervical carcinoma which has been achieved in part because of the reliability of cytology as a screening and diagnostic procedure.

In summary, cytology is a diagnostic procedure of proved worth, and in a private hospital laboratory, is a most useful adjunct to the diagnosis of disease. If used properly, cytology can increase accuracy of diagnosis. It can increase detection of early, asymptomatic carcinoma, and thus should increase the survival rate in cancer. Lastly, it will assist in making good careful follow-up studies in patients with known cancer, and survival rates will increase correspondingly. A cytology service can do much to satisfy the need for such procedures.

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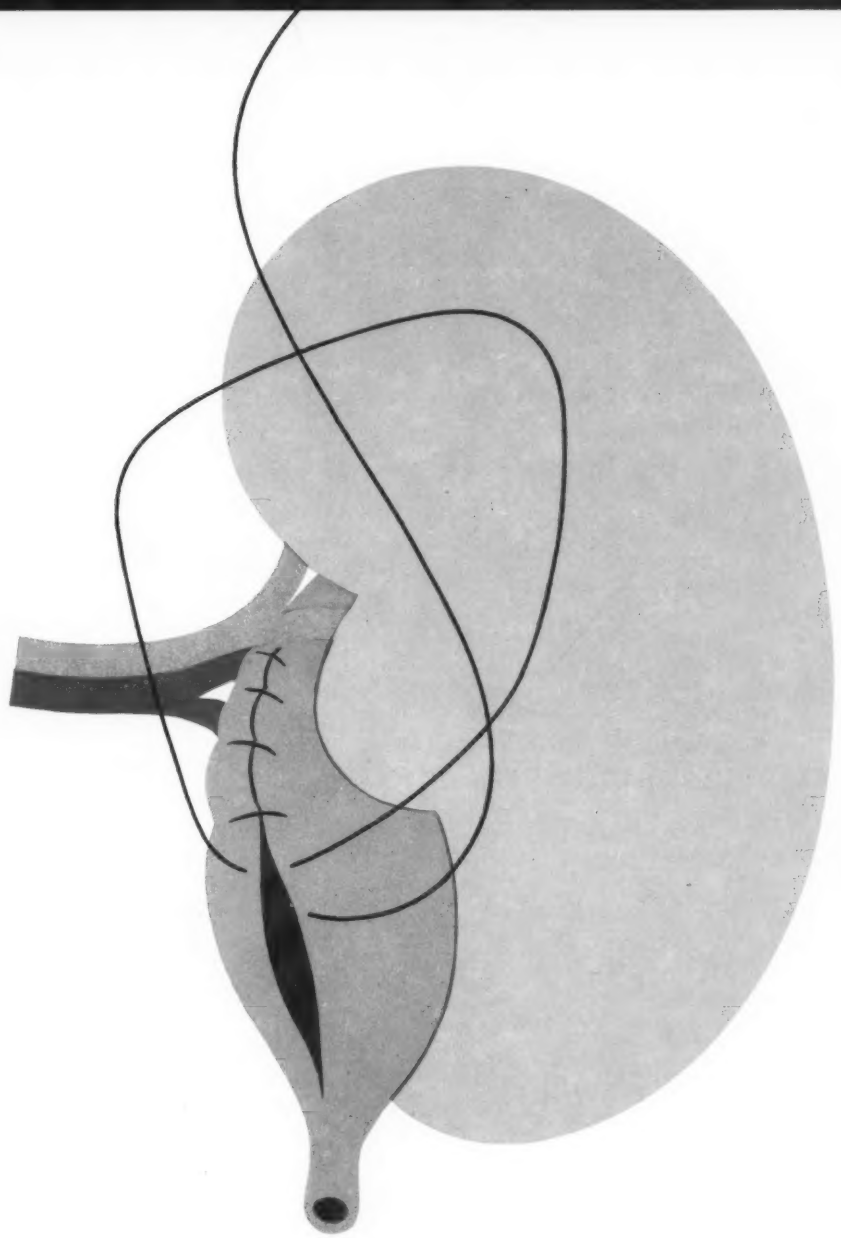

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The Book Corner

Modular Management And Human Leadership. By Frank Pieper. Minneapolis, Minn.: Methods Press. 1958. 287 pp. $6.50.

A practical manual for foremen and supervisors on how to help workers work, this book presents a down-to-earth analysis of what a leader must do in order to "lead." An example of the realistic approach is the scale by which a leader can see how he talks both to and with workers—how "directive" or "creative" he is with them—as he leads them.

Modular management is the concept of management in a work environment, which emphasizes units of operation and production. Modern production methods have created conflicts with personnel, who are made to feel like things rather than people. "Management by measurement has made us forget that workers will produce exactly as much as they feel like producing."

Modern production methods are in conflict with basic human needs —defined as needs for recognition, understanding, security, and new experiences.

These functions of the job supervisor are defined: Analyze work—decide what you expect; orient and train workers—communicate what you expect; organize, plan, schedule, and expedite work; assign work and responsibility; prevent or solve problems; improve work methods; evaluate work and let workers know where they stand; build team feeling; use staff services; keep workers and managers informed.

This book emphasizes the idea of the employee as a "total man." It points out that the employee can not be considered simply as the person he is during his working hours, which represent only a quarter of the total year. The leader or supervisor must obtain the confidence of his subordinates and learn to know them thoroughly. This is the first step in creating a team.

The book is highly practical. It is simply written, and contains many realistic examples. Its practicality is demonstrated by the section titles. Some examples are:

—How to Write a "How-to"
—How to Expedite
—How Workers Feel about Leading
—Your Self-control in Leading
—You Can Prevent Problems
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3. Think of as many alternative solutions as possible.

4. Select the best or most workable solution by comparative test.

5. Spark action!

The writing style is warm and sympathetic. The section on methods analysis, titled "There's Always a Better Way," does not talk down to the reader or complicate the ideas presented with jargon.

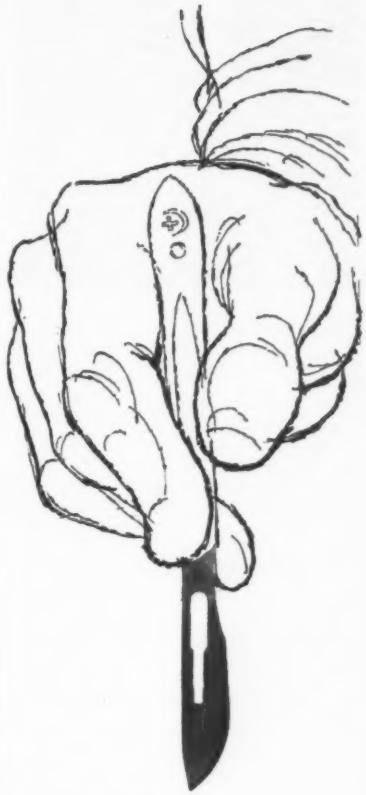
This book has practical value for supervisors, particularly those who are responsible for persons who may easily lose their identity in the hospital organization such as nurses aides, diet maids, and housekeeping personnel.—*John G. Steinle,* Consulting Editor.

Define Guides for Fees In Psychiatric Clinics

Answers to the questions of why, whom, how, and what fees should be charged in voluntary psychiatric outpatient clinics are contained in a booklet recently published by the Community Council of Greater New York.

The findings are based on the report of a technical subcommittee of the council's mental health committee.

Recommendations for general principles and reasonable standards in this field are presented so that deviations in actual practice may be made on a sound basis. General considerations and computations are dealt with thoroughly and practically. Price of the booklet is $1 a copy; it is available through the council at 345 East 45th St., New York 17, N.Y.



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Pediatrics

Artist's Gay Murals Brighten West Coast Pediatrics Units

Meet Wolo — a "therapeutic artist"

Above: The artist at work on a wall mural on the pediatrics floor of Brookside Hospital, San Pablo, Calif. After drawing his characters in chalk, Wolo then finishes the murals in the vivid colors he knows children love. Below: Mural behind reception desk on Brookside's pediatrics floor invites children to take a trip with Mingo the puppet to "Get-Well Island."

• A "therapeutic artist" is Wolo von Trutzschler's description of himself. Now at work on his ninth set of murals for hospital pediatrics units (see story on Brookside Hospital, page 39), he has also created gay little animal characters for various doctors' and dentists' offices on the West Coast.

Nurses say that Wolo's murals accomplish their purpose, which is to help ease children's fears about the strange and thus frightening experience of hospitalization. The first thing children see when the elevator doors open on the pediatrics floor at Brookside is a happy clown on the opposite wall. As they turn left, they spot the large mural on the wall behind the reception desk. It has a "cast" of nearly 30 different kinds of creatures—birds, rabbits, squirrels, bugs—and a group of smiling children being led aboard a homemade sailboat by a little puppet named Mingo. Mingo is taking the children to "Get-Well Island."

Each child is given his own Mingo puppet and can thus go with him on the journey to that imaginary island.

On another wall, a saucy-looking cat sits atop a stack of seven or eight pillows—each painted a different vivid color.

Wolo is now working on still another wall—showing children marching along in a cowboy band, while on a tree limb overhead, happy little bear cubs dance to their music. Another mural to come will show a merry-go-round scene.

In the "Little Jim" ward at Children's Hospital in San Francisco, Wolo painted a different animal over the door to each room. There are bears, monkeys, kangaroos—all with gay expressions, all in the vivid colors Wolo knows children love. Large wall murals decorate two of the wards. One shows all kinds of animals popping out of tree houses, while not far away are children on an appealing little island, something like Mingo's "Get-Well Island" at Brookside Hospital.

The colors are as bright as when they were painted, more than two years ago. Wolo prides himself on using only the finest oil paints—he calls them "lollipop colors."

At right: Wolo and Aloysius, his little mouse puppet, delight young patients at Children's Hospital, San Francisco, as Aloysius attempts to steal a drink from the luncheon tray of girl at right. When Wolo is painting murals in hospitals, he is often called away from his work to meet some of his young fans. Wall mural behind beds is one Wolo did more than two years ago.

Below: The companion to the mural shown above is this one in another ward at Children's, San Francisco.

There is always a story to Wolo's murals; in fact, he writes it down for the doctors or nurses who may be asked what the little creatures are doing. But he finds that the children make up their own stories in which they themselves participate.

In painting the murals, Wolo puts in many tiny details and many things on or near the ground. As he explains, children notice such little things, which are literally more on their level.

Wolo's mural-painting is often interrupted by a request from the nurses to visit one of his little fans, for Wolo, as a puppeteer, is one of the most popular television performers for children in the San Francisco area. His co-star in his appearances on a morning show five days a week is a little mouse puppet named Aloysius. When Wolo goes to a hospital, whether to work or to entertain, Aloysius usually goes along, and many a child has been thrilled by having a personal interview with Wolo and Aloysius.

The artist has always loved children. His own two are now grown. His daughter, busy raising her own family, still finds time to make clothes for some of the little puppet characters which appear with Aloysius.

Wolo is the author of six children's books, which are illustrated with his drawings. He says he has plenty of ideas for other books, when he finds the time to write them.

His first hospital murals were done at the Stanford Clinic in Palo Alto, about nine years ago.

Since then he has completed murals in the pediatrics floor of the Palo Alto Hospital; the Palo Alto Clinic; the Baby Showcase at the Palo Alto Hospital; Redwood City Hospital; Menlo Park Clinic; pediatrics floor of the Salinas (Calif.) Hospital; Expectant Father's room, Salinas Hospital; Little Jim ward, Children's Hospital, San Francisco; Brookside Hospital, San Pablo, Calif.; plus an orthodontist's waiting room, and a pediatrician's waiting room.

One job has led to another. In several instances the women's auxiliary has made the murals its special project.

Too often, Wolo comments rather sadly, hospitals seem to consider murals a nice "frill," to be added if anything is left in the budget after the hospital is built, equipped, and staffed. Why, he says, shouldn't something which so definitely improves patients' morale be considered an essential?

Hospital murals should not be limited to pediatrics wards, he believes.

"Why not give adult patients a pleasant scene to look at—perhaps a peaceful landscape that will take them temporarily out of their hospital surroundings?"

He speaks with a kind of missionary zeal—not just for himself, but for every artist who might paint such murals and every patient who might get some pleasure from them. As for himself, he hopes he can paint many more scenes to gladden the hearts of patients—children and adults.

Pediatrics in Transition, Poison Control Centers Discussed at AMA Session

• *The following abstracts are of selected papers presented before the pediatrics section at the recent annual convention of the American Medical Association in San Francisco. See the August issue, pages 26-30 and 33-40, for other news of the convention and for a special report on the scientific exhibits.*

Pediatrics in Transition; Pediatrician May Be Family Doctor of Tomorrow

Immunization, Antibiotic Therapy Influence Number of Pediatric Admissions

Pediatrics is in transition from a disease-oriented specialty to a child-rearing specialty. The pediatrician's practice has changed from one largely composed of diagnosis and treatment of very sick children to one in which child-health supervision, diagnostic problems, and management of special disorders, such as prematurity and crippling conditions, predominate.

A recent statewide survey of a group of pediatricians indicates that about half of them thought that allergy and psychological aspects of behavior problems should have received greater emphasis in their training.

Immunization and antibiotic therapy have had a great influence on hospital admissions, both by making it unnecessary for some patients to be hospitalized and by reducing the length of stay for others. Indiscriminate use of antibiotics has contributed several new problems, however, such as resistant infections and toxic reactions to these drugs.

Trauma and accidental poisoning have become more frequent phenomena as diseases have been more effectively controlled.

The pediatrician may be the family doctor of tomorrow. He is better prepared at present than physicians in any other branch of medicine to apply and develop principles of preventive medicine and care for the entire family's health.—*George M. Wheatley, M.D.*, New York City.

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126 Poison Control Centers Operating; 90% Are Found in Hospitals

Results Reported with Latest Methods For Treating Various Types of Poisoning

Since the first poison control center was organized in Chicago in 1953, 126 such centers have been established in 40 states and territories.

Eighty-five percent of the centers have facilities for treatment. Others merely furnish information, but treatment is available at nearby co-operating hospitals.

Many centers are actively studying the problem of accidental poisoning. Sixty-six percent follow up cases of poisoning treated at the centers or brought to their attention.

Nearly 90 percent of all centers are in hospitals. Often more than one agency or organization sponsors or supports the center.

The National Clearinghouse for Poison Control Centers serves as an informational agency for the 126 centers. Statistical facilities are available to any center for analysis and tabulations of poisoning cases. Comprehensive data are available from the thirty centers which use these facilities. Statistical summaries are available from most of the other centers. The data will be presented and compared to accidental poisoning mortality figures obtained from the National Office of Vital Statistics.

Exchange transfusion is being employed more frequently in the treatment of acute poisoning in children, especially in cases of acute, severe salicylism. More experience with this method is needed in order to evaluate it properly.

Incidence of neurologic sequelae from lead poisoning may have been reduced by introduction of Ca.-EDTA (edathamil calcium disodium) therapy. Although this de-leading agent is the best developed to date, it has not significantly reduced mortality from lead poisoning in children. It usually must be administered from 48 to 72 hours to sufficiently reduce potentially lethal concentrations of lead in the tissues to less toxic levels. It is in this period, after the onset of acute symptoms, that most deaths from acute lead encephalopathy occur.

There is no substitute for rigorous prevention of exposure to lead and early diagnosis of lead poisoning.

Recent development of a quantitative chemical analysis of venous blood for the aromatic fraction of kerosene should give us more information about the pathophysiology of kerosene poisoning, and thus lead to more effective and uniform therapy for petroleum distillate ingestion.—*Howard M. Cann, M.D., Dorothy S. Neyman,* and *Henry L. Verhulst,* U.S. Public Health Service, Department of Health, Education, and Welfare, Washington, D.C.

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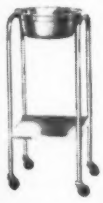

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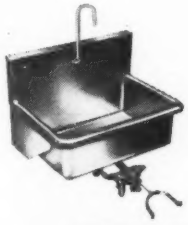

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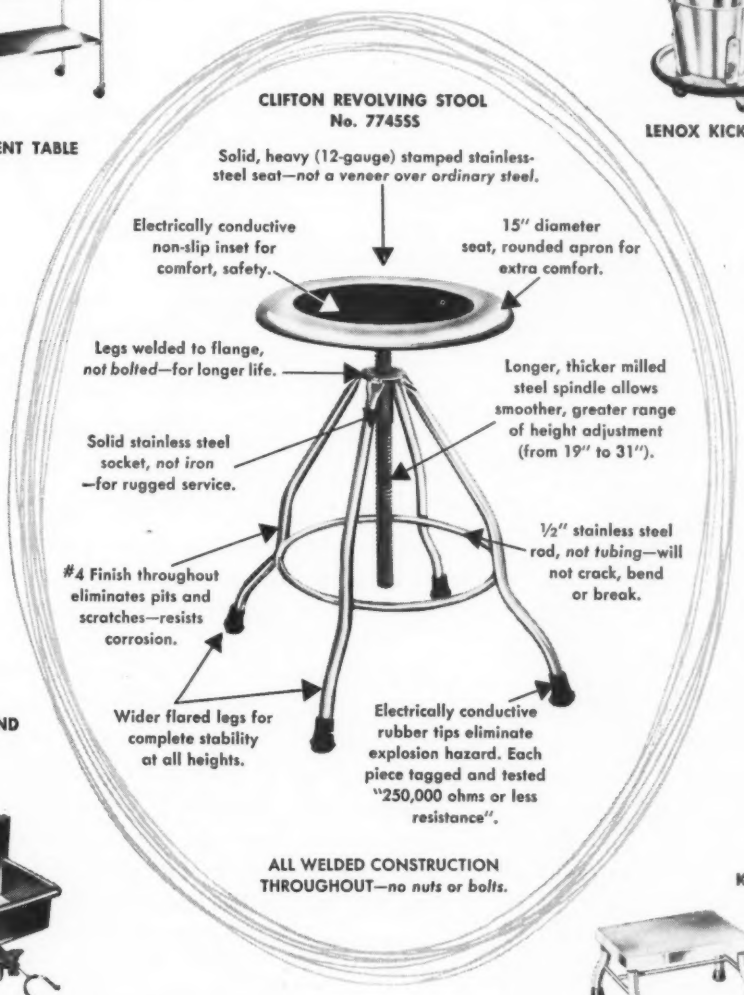
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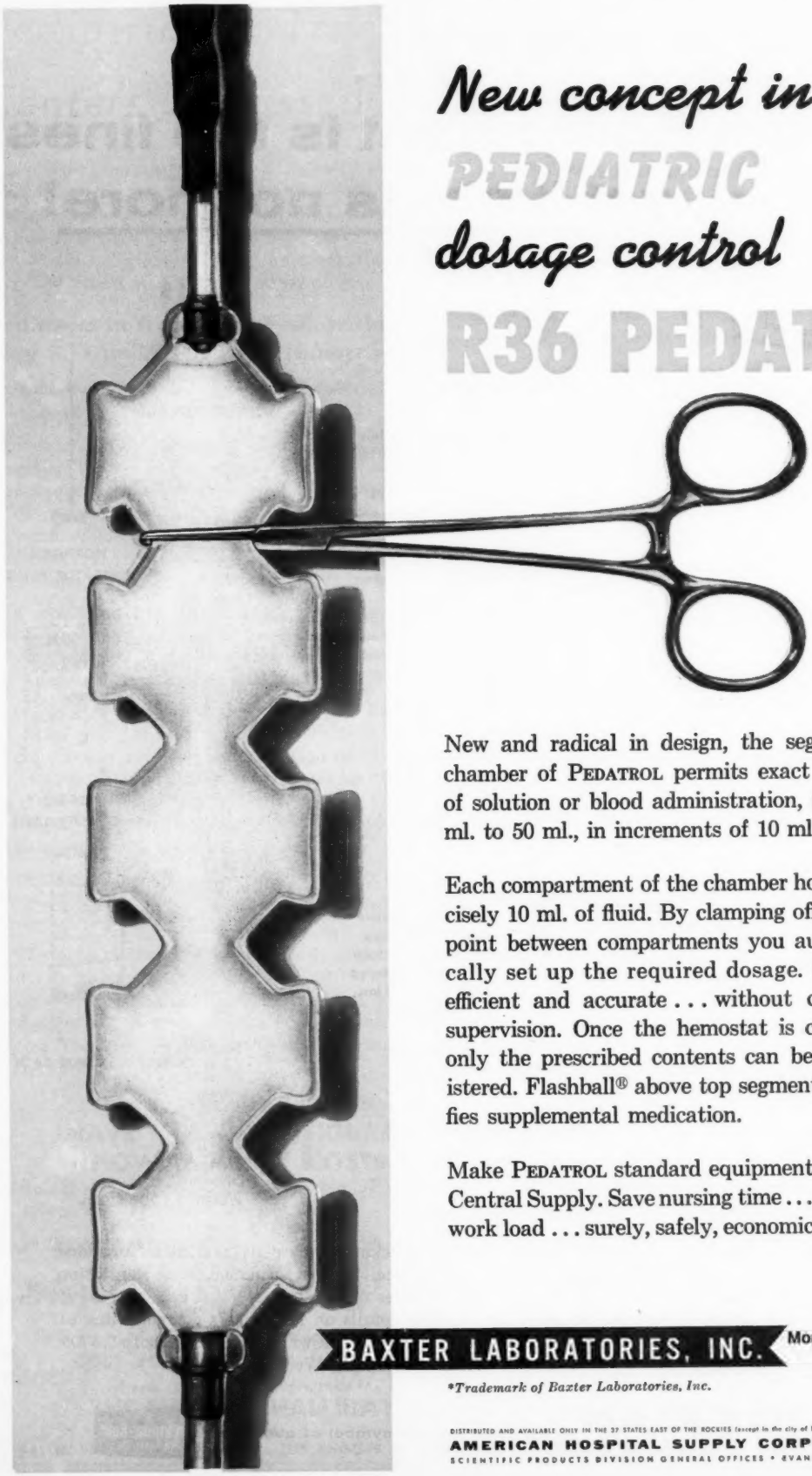

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Florida Seminar Demonstrates Care Of Premature Infants

OB DEPARTMENT

A five-day seminar for physicians and nurses on "The Care of Premature Infants" was held May 19 to 23 at the Premature Demonstration Center, University of Miami School of Medicine and Jackson Memorial Hospital, Miami, Fla., under the auspices of the Florida State Board of Health.

The meeting opened with a comprehensive but specific discussion of the causes of prematurity, the obstetrical problems involved, and the technics of care used. Highlights of this discussion and abstracts from separate sessions of the seminar follow:

• Fifty percent of all prematurity is of unknown cause and less than 50 percent is concerned with obstetrical factors.

In statistical studies at several large teaching centers, from 7 to 11 percent of all deliveries were found to be prematures. At Cook County Hospital, Chicago, with 24,000 deliveries a year, 83 percent of neonatal deaths were shown to be associated with prematurity.

Ninety-four percent of infants weighing between five and five and one-half pounds survive, whereas there is less than three percent survival of infants under two pounds.

Toxemia of pregnancy is a large factor in causing prematurity. In toxemia, socioeconomic aspects are significant. It is estimated that 90 percent of the cases of fulminating eclampsia could be avoided by good prenatal care. In diagnosis, puffiness of the face and marked swelling of the fingers are more significant than dependent edema, to which every pregnant woman is subject.

In the management of the eclamptic patient, restraint, oxygen, and careful sedation are important. Sedation must be employed within safe limits. When sodium pentothal is given in a slow intravenous drip, the mother's blood is titrated regularly and her pressure checked to be sure she is not experiencing a hypotensive effect which could result in hypoxia in the infant.

Digitalization may be indicated for tachycardia, and if the patient is not aerating well, tracheotomy may be necessary. Convulsions should be controlled for 24 hours before the pregnancy is terminated.

If pitocin must be used, extreme caution should be exercised. Pitocin is usually given intravenously in 1,000 cc. of five percent distilled water with repeated measurement for control of the circulating level.

Section must be done under local anesthesia. Spinal anesthesia may produce a hypotensive effect in the mother and consequent hypoxia in the infant, who is prone to intracranial injury.

Fibroids are likely to induce premature labor, and myomectomy can be performed up to and during the second trimester.

Many babies are lost as prematures when the obstetrician is deceived by signs and performs a cesarean section too early. However, one legitimate cause for prematurity is interruption of the pregnancy because of the detection of invasive carcinoma. In such cases, section is done at 30 weeks; a classical section can be performed because the pregnancy is normal. The baby would have a better chance at 36 weeks but the mother's chances would be jeopardized.

DIAGNOSIS MUST BE MADE EARLY

If the diagnosis of carcinoma is made early enough in the pregnancy, the prognosis for the mother is as good as that for a nonpregnant woman. All patients with lesions of the cervix must have a Papanicolaou test and a punch biopsy. When premature rupture of the fetal membranes is suspected, cervical smear and cytological examination for vernix caseosa cells is done to confirm the rupture.

In such cases, the patient is given antibiotics and bed rest until labor. Analgesia is avoided during labor; local anesthesia is used during delivery. A conservative episiotomy can be performed because the head of the infant is small and compresses easily. However, the head should be subjected to as little compression as possible to avoid the possibility of brain damage.

Insofar as the treatment of prematurity with the new hormones is concerned, it is likely that the shock of their expense would be enough to induce labor. Studies on these agents are not conclusive.

In a recently developed technic, a purse string suture is placed around the cervix of the patient in whom labor threatens 16 to 18 weeks prematurely. This procedure was adequate to prevent labor until term in 80 percent of the cases treated.

All maternal hemorrhaging appears to be associated with prematurity. With marginal or partial placenta previa, it may be possible the carry the mother and infant until the baby reaches a weight of five pounds. Examinations are avoided.

(Continued on next page)

Ideally, after partial placenta previa had been diagnosed by examination in the operating room, the patient would be kept in the hospital until she was ready to deliver. However, economic factors militate against this and the patient must be sent home and followed carefully.

Painful bleeding in the third trimester from a normally situated placenta signals a ruptured placenta and in such a case, there is *no room for conservatism* in treatment. Blood replacement is started immediately, blood studies are done, and the uterus is emptied. Vaginal delivery is tried if possible; if it is impossible, cesarean section is necessary.

Rupture of the margnial sinus is an unappreciated source of hemorrhage and a difficult one to detect since the diagnosis cannot be confirmed until the placenta is actually in hand. Sometimes diagnosis is made by exclusion. In one series of 98 cases, gestation was at about 36 weeks. Symptoms included painless vaginal bleeding; lack of pain or tenderness; and, in one patient, hypertonic uterus.

Daily reports are taken at 5 a.m. and 5 p.m. for all infants in the premature center. These reports rate the condition of the infant as good, fair, or poor.

A detailed prenatal and delivery summary is kept, as is a discharge summary. The Dade County Health Unit makes an exhaustive investigation of home conditions and facilities, and reports its findings to the hospital before prematures are discharged.

Not content with its comparatively limited observation of the babies who start life under its care, the center asks the co-operation of physicians in filling out detailed reports on the youngsters' six-month, one-, two-, and five-year examinations. A similar check on eye examinations is made on a three-, four-, and six-month basis. These reports serve to bring into focus the center's original contribution, and provide invaluable medical histories.

Proved Skills Are Prerequisite For Premature Center Nurses

In-Service Teaching Program Keeps Staff Alert, Informed

Nursing service assigns a given number of nurses to pediatrics. After orientation in pediatrics, nurses with a stated preference for premature nursery work, or who have shown exceptional skills in infant care are assigned to the Premature Demonstration Center.

A registered nurse is assigned to each nursery and is helped by a closely supervised aide. Licensed practical nurses have not been assigned to the premature center because it is felt that they are more useful in the pediatric division.

Although nurses are equipped to work in both the pediatrics division and the premature center, a nucleus of permanently-assigned personnel is maintained in each; other personnel are rotated as needed. An in-service teaching program keeps the whole staff alert. Ten teams of doctors and registered nurses have taken the month of training offered by Cornell University, Ithaca, N. Y.

Student nurses spend 14 weeks in the pediatrics department, two weeks in the premature center.—*Mrs. M. Gannaway, R.N.*, supervisor, pediatrics division.

One Nurse at Center Is Responsible For 5 or 6 Premature Babies

Newly Assigned R.N.'s and Student Nurses Fully Oriented

At Jackson Memorial Hospital, the registered nurse in each nursery is responsible for the total nursing care of five or six babies. She is assisted by one aide who does general cleaning, prepares supplies, and performs similar duties.

Student nurses and newly assigned R.N.'s are oriented and supervised by the nurse in charge. Every infant is under constant observation; nurses in adjoining nurseries relieve each other for breaks.

The housekeeper of the hospital has been taught the precautions to be observed in cleaning the nursery; a maid, under her direction, is allowed in the nursery once a day to wet mop and dust. Once a month, nurseries are emptied in rotation for complete cleaning.—*D. Rada, R.N.*, head nurse, Premature Center.

Lists Hints for Recognizing Congenital Abnormalities

Nurses Told What to Look for And What Findings Indicate

The nurse should know the signs indicative of congenital abnormalities so that she can recognize and report them. The following are some hints.

Although cardiac abnormalities do not usually appear for six or seven months, every newborn should be inspected for cyanosis or a bulge over the heart area.

In any respiratory distress, the mouth should be inspected, the tongue freed, if necessary, and an airway provided. In an infant, if the posterior choanae are closed by atresia, its attempts to breath will create a vacuum which will cause the tongue to seal on the roof of the mouth.

An abnormal amount of mucus may signal a tracheo-esophageal fistula.

The direction in which the infant's umbilicus moves as it breathes should be watched. If the umbilicus moves in any but a straight, vertical plane; if the infant has respiratory difficulty, breathes asymmetrically, or has cyanosis—diaphragmatic hernia may be suspected.

Every anal opening should be inspected for characteristic anal pigmentation. Although imperforate anus is seldom missed, a fistula in the perineum may be deceiving.

Any baby who vomits bile is considered to have intestinal obstruction until proved otherwise.

If the infant voids in dribbles; if the anus is very relaxed—central nervous system abnormality should be suspected.

(Continued on page 107)

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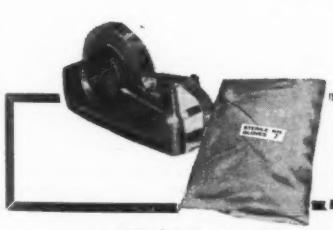

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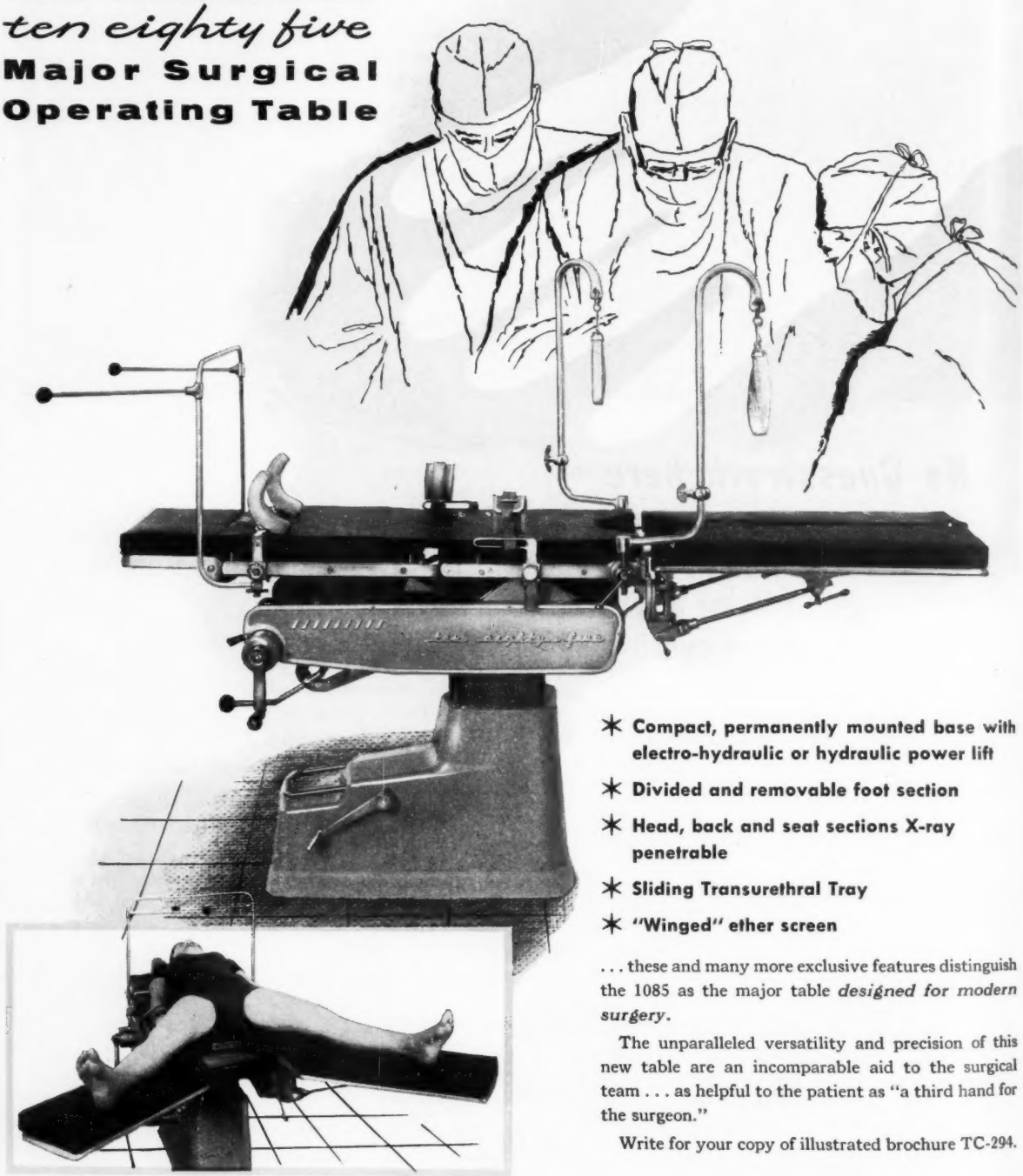

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(Continued from page 104)

Moles and hemangiomas should be inspected carefully to be sure they do not disguise a tiny sinus which may run to the spinal tract.

If small drops of fluid are found on the skin lying over the spinal canal, a dermal sinus may be suspected. If one is found, it must be closed promptly to prevent meningitis.

Every infant, male or female, should be watched for signs of strain while voiding; the stream of urine should be checked. Abnormalities of the genitourinary tract must be detected and treated early to preserve the kidneys.

Masses in the lower abdomen in infants may indicate an obstruction to the outflow of urine.

In females the clitoris should be examined for enlargement. An abnormality is evidence of impaired hormone production. One extreme of this condition is Addison's disease. Projectile vomiting often accompanies this syndrome.

If the position of a hand or a foot is puzzling, or if a dent appears in the skull, the baby should be wiggled or pushed into the "position of comfort"—the position of the baby in utero. Attainment of that position can be recognized by the complete relaxation of the infant. Once the infant finds this position, a questionable "deformity" may prove to be merely a temporary result of pressure and position.

In summary: Never hesitate to call the physician's attention to a baby who simply "doesn't look right."—*D. G. Traggis, M.D.*, assistant professor of pediatrics.

Retrolental Fibroplasia Called Most Common Blindness Cause in Children

Damage Directly Related To Use of Oxygen

Retrolental fibroplasia is the most common cause of blindness in children. Its occurrence is directly related to the use of oxygen.

Studies show that concentrations of 35 to 40 percent oxygen administered continuously over ten days, and 80 percent oxygen administered over two hours will cause retinal damage. Any concentration over 40 percent will cause damage in three to four days, whereas a concentration of less than 40 percent has no effect on the retina in the same time interval. Maximal damage occurs with the use of oxygen concentrations of 80 percent and over.

Intermittent oxygen administration is preferable to continuous administration. Personnel must be carefully instructed concerning the hazards of oxygen therapy. Oxygen analyzers must be used at regular intervals and the concentrations recorded on the infant's chart.

Oxygen should never be used without a doctor's order. The concentration should be the lowest possible to evoke response, and the therapy should be discontinued as soon as possible. When positive pressure is used, a mask small enough to effect a tight seal with the face is essential, and pressure should be kept at a level no higher than 12 mm. Hg.

Infants' eyes are examined when weight has reached three pounds. Retrolental fibroplasia has been detected as early as the first or second day of life. If no signs of the disease appear by the fourth month, it is unlikely that the condition will occur.—*D. G. Traggis, M.D.*, assistant professor of pediatrics.

Feeding of Premature Starts 24 to 72 Hours After Birth

Technic Is More Important Than Type of Formula Used

Babies are born with a "built-in" clysis. They are full of fluid and can get along well without supplemental fluids for periods of from 24 to 72 hours after birth.

Nothing is given to the newborn for the first 24 hours. As soon as the baby is stabilized at a constant temperature, and regular respirations and stool and urine have appeared, it may be started on a formula. But the choice of formula is not as important as the technic of feeding.

Newborns metabolize fat poorly. Fat in a formula appears in the stool unchanged and there is an even exchange of calories taken in and excreted. When an infant reaches a stabilized food intake, it requires 50 to 60 calories per pound of body weight per day; this amounts to about 70 to 90 cc. of fluid per pound per day. The stock formula used at the Jackson Memorial Hospital provides 23 calories per ounce. In six years, the formula has caused no reactions or diarrhea in the infants.—*R. Grayson, M.D.*, clinical assistant professor of pediatrics.

Premautre Infants Highly Susceptible To Infections by Bacteria, Fungi

Aseptic Technics Still Are Most Important Preventive

Premature infants have no ability to withstand attack by bacteria or fungi. They have some protection against viruses, but are immensely susceptible to other infections.

Their skin is thinner; their lungs are full of unfreed secretions. Although the incidence of gastrointestinal infections may not be greater in prematures than in other infants, nevertheless mechanical factors in the prematures predispose them to infections.

There is a complete lack of immunologic response in prematures. Antibodies are usually passed over in the mother's serum; these are at a very low level in the infant until about two or three months when it begins to produce its own.

The premature has little, if any, protection against infection from staphylococci, Monilia, or Gram-negative rods. Infants become colonized with staphylococci shortly after birth. Most staphylococci are benign but epidemic strains have developed which can be, and are, identified by phage typing.

These organisms are spread in a variety of ways. Chronic carriers of epidemic strains are particularly

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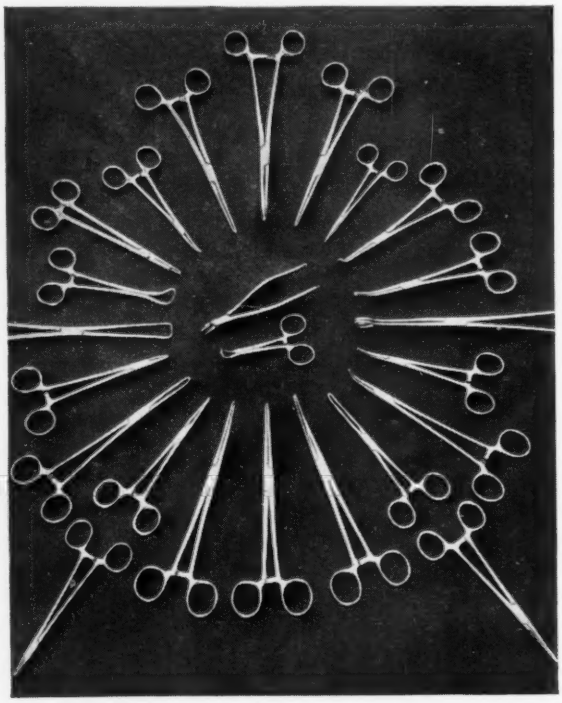

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dangerous, and nose, throat, and skin cultures should be taken at regular intervals from nursery personnel to guard against these chronic carriers.

A single stool culture is valuable to detect the occasional person carrying pathogenic intestinal organisms. It is most important that personnel who have chronic sinusitis, perineal infections, skin lesions, or other taken-for-granted low grade infections realize the hazard they present.

Careful handwashing is probably the single most important technic for control, but it alone is not sufficient to control infections. Masking is of only relative efficiency.

Permanent nursery personnel are carefully screened for organisms in the nasopharynx and do not routinely wear masks. Personnel from other areas of the hospital, however, must wear masks.

Personnel from the nursery do not work in other hospital areas. If an emergency arises and they must work in a contaminated area, several days must elapse before they may return to the nursery.

EPIDEMICS TRACED TO POOR TECHNICS

Diarrhea caused by enteropathic *E. coli* is rarely found in adults, but they may introduce the disease to nurseries. Most epidemics generally can be traced to poor technics.

Proteus and Pseudomonas infections may arise from contaminated disinfecting solutions; dirty water traps; or dirty water mists in Isolettes. They also circulate in the air.

These organisms are dangerous as secondary invaders. Pseudomonas skin lesions secondary to burns or disease are firm, red, insect bite-like lesions which later break down and become gangrenous ulcers.

Monilial infections in the newborn can be traced to the mother's vaginal secretions. They are a problem for the obstetrician to recognize and treat.

The approved method of using antibiotic therapy is to treat the specific infection with a specific antibiotic. There is no general agreement on the worth of routine antibiotics for prematures to prevent primary or secondary infections, but the consensus is generally swinging away from prophylactic therapy of any kind. The staphylococci and Gram-negative rods—organisms figuring prominently in nursery infections—are not diverted by prophylactic antibiotics. Use of Gantrisin should be avoided in prematures because it may precipitate jaundice.

Prophylaxis for gonorrheal ophthalmia is still necessary. The tendency now is to use Terramycin and polymyxin ointment rather than silver nitrate.

The biggest factor to realize in therapy is that no antibiotic can be a substitute for good and fastidious technics. Understaffed nurseries, or those staffed with poorly trained workers all contribute to morbidity and mortality statistics. No antibiotic will eliminate the hazard created by personnel.

(Continued on page 110)

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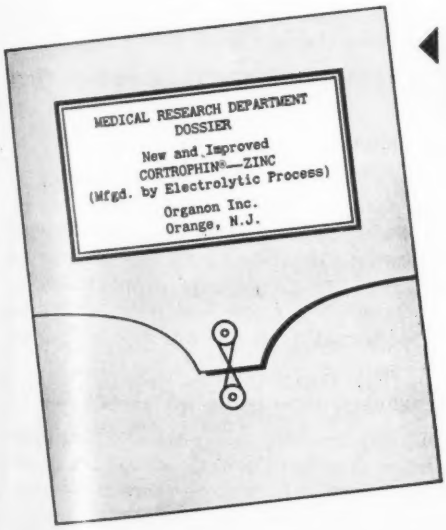

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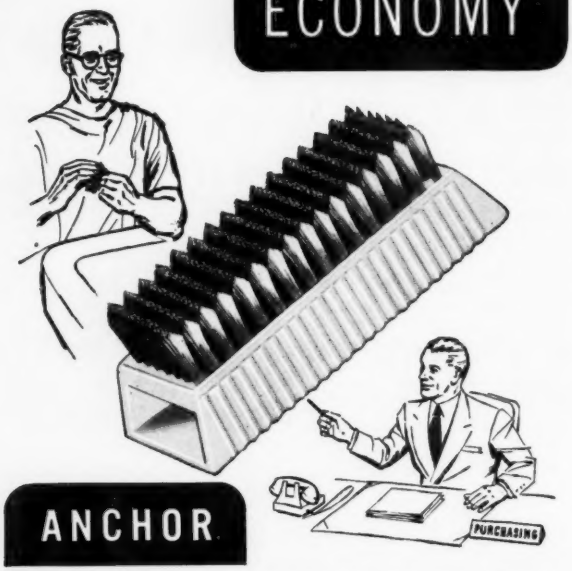

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OB DEPARTMENT

(Continued from page 108)

Successful treatment of nursery infections depends on identifying the causative organisms and determining their sensitivity to various drugs.

The ordinary tiny pimples which develop on the newborn's skin from skin secretions should not be confused with impetigo. The pimples are noninfectious; impetigo, however, is infectious and the infant who contracts it should be isolated. Infants with heat rash are particularly susceptible to impetigo. Treatment of the disease includes parenteral and local medication.

It is important to realize that many staphylococcal infections may actually arise in the nursery but will go undetected if they appear in the infant after discharge. —*Robert B. Lawson, M.D.*, chairman, department of pediatrics.

Questions and Answers

Q. What is the average feeding for a three-pound infant?

A. A safe rule of thumb is to give twice the weight of the infant in cc.'s per feeding. This may not provide sufficient calories or fluid over a period of time but these can be built up.

Q. Do you start the infant on water before initiating feedings?

A. The infant may go from 48 to 60 hours after birth with no feeding or fluid. Water is usually started 12 to 36 hours before feedings are begun.

Q. Do you alternate feedings from tube to nipple?

A. After the infant begins nipple feeding, the tube is left in place for a time and is used when the baby shows signs of becoming tired from sucking.

Q. Do you always feed infants under three pounds by tube?

A. Yes. It is a very rare occasion when a baby of three pounds acts like a five-pounder, but when such a baby does appear, it is offered nipple feeding.

Q. Do you exclude, from the nursery, personnel whose throat cultures have shown "yeast"?

A. No. Infants pick up their monilial infections from their mothers.

Q. How long should a person with a common cold stay out of the nursery?

A. The person with a common cold is not as dangerous as is the person with chronic sinusitis or with some other chronic infection which has become so much a part of the person's make-up, it is overlooked. However, a person with a fresh cold is dangerous enough to be kept away from the nursery as long as symptoms persist.

Q. How often should water traps be cleaned?

A. They should be removed, cleaned, and sterilized between patients. The outflow trap should be examined at regular intervals to be sure there is no back drainage.

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Now everybody's talking...

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Wider recognition of the current problem of hospital-acquired infections is focusing new attention on ways and means of reducing this hazard to good patient care. Hospital and medical society meetings—and hospital, medical and surgical journals—are daily shedding new light on the varied aspects of the overall problem.

In many hospitals, a special "committee on cross infection" has been appointed to review practices and procedures. In others, each department head is studying closely his or her own methods of operation. Few hospitals exist which are not giving some special thought to this highly current problem.

Out of this critical evaluation has grown an awareness that environmental asepsis is a major weapon for cutting cross infection to a minimum. Application of continuous disinfection procedures from operating rooms through food service and laundry areas can be the means to changing the hospital's entire experience with hospital-acquired respiratory, intestinal, urinary or post-operative wound infections.

Take floors, for instance

Floors offer a great opportunity for furthering the spread of infection. Microorganisms settling to the floor are redispersed on dust particles or tracked through the hospital on shoes. Walls and ceilings as well can be reservoirs of potential infection. Lehn & Fink disinfectants not only kill all the most common pathogens on contact but are continuously active against new contaminants touching the disinfected surface for as long as a week later.

While the patient is there

Concurrent disinfection is practical whether or not the patient is "isolated." Wiping of furniture and fixtures and damp mopping of floor, with a disinfectant, stop air- and floor-borne microbes at the source.

In the operating room

Lehn & Fink disinfectants have many applications here. Among them: mopping floors; cleaning grills, ducts, and coils of air conditioners; as standard equipment on the scrub-up cart; as a germicidal dip to remove gross contamination from gloves before their removal; to gather instruments into enroute to sterilizer.

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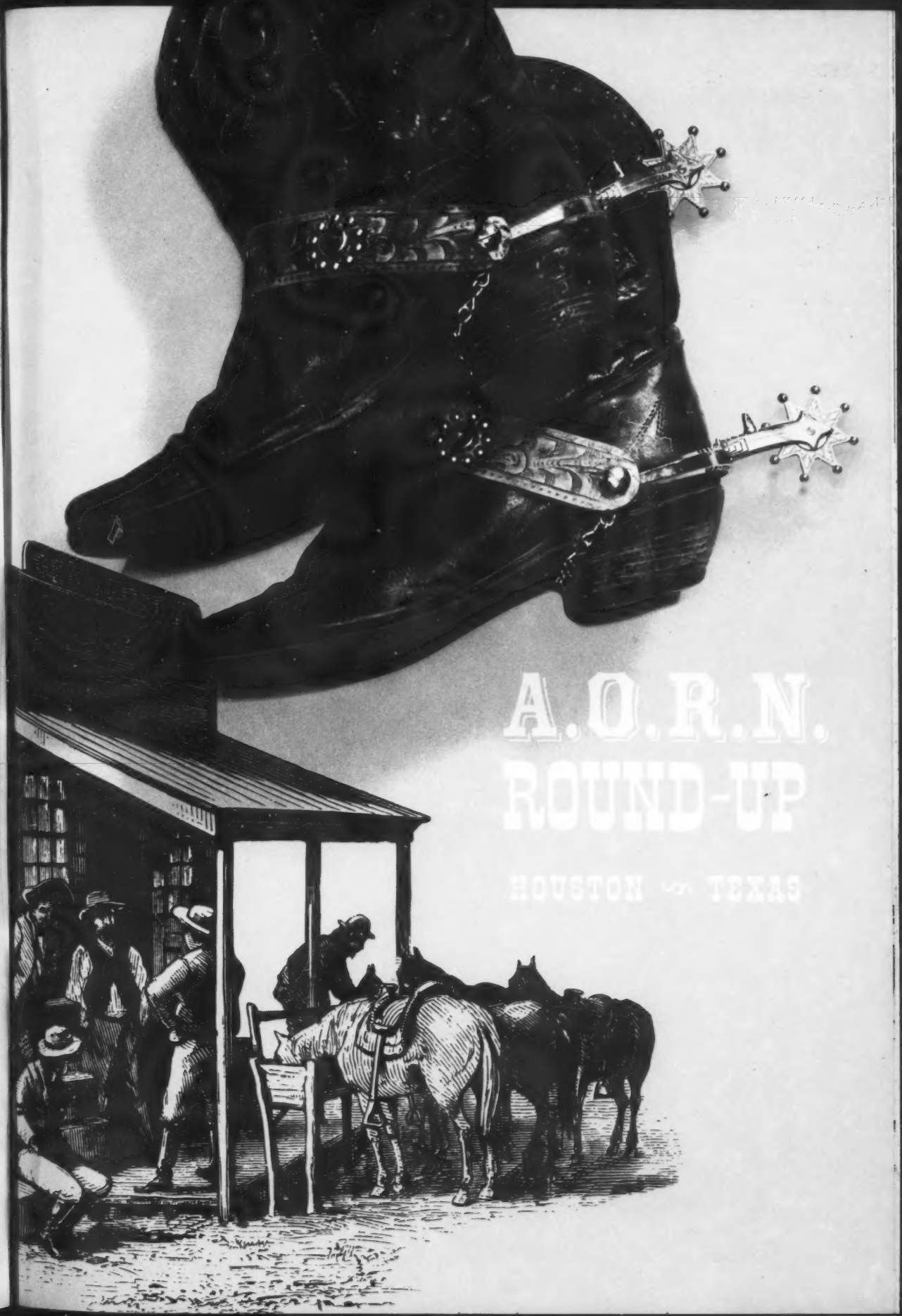
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Polio Foundation to Expand Into Other Disease Areas

A scientific assault on major health problems will be made by the National Foundation, new name adopted by the National Foundation for Infantile Paralysis, which has launched a broadened program.

Projected plans center around medical research, patient aid, and professional education. Virtual conquest of paralytic polio by the Salk vaccine has made the new program possible.

Keynote of the future program will be research, with arthritis and congenital malformations as first targets. Plans are eventually to offer aid to arthritis patients, through 18 years of age, and to children suffering from malformations of the central nervous system.

Virus research and investigations into disorders of the central nervous system will be continued and expanded. All areas of the expanded program will be financed through the traditional March of Dimes each January.

Rehabilitation Institute Opened in Boston Hospital

A $1,300,000, five-floor Rehabilitation Institute, the first unit of its kind in New England, was opened recently at the Boston Dispensary to meet the needs of an estimated 116,000 physically handicapped persons in a six-state area.

The structure is designed with single, double, and four-patient occupancy bedrooms, to accommodate 23 house patients, and a daily outpatient load of 100.

Emphasizing total rehabilitation and self-help, the institute enables patients to make their own beds, prepare snacks in fully equipped practice kitchens, wash their own clothes.

Started as a 10-bed pilot project in 1954, the unit has expanded to meet increasing demands for treatment. The new building also houses the Arthur G. Rotch Rehabilitation Research Center.

John J. Lorentz, M.D., is physician-in-charge. Edward H. Frieden, Ph.D., directs the basic and clinical rehabilitation research studies.

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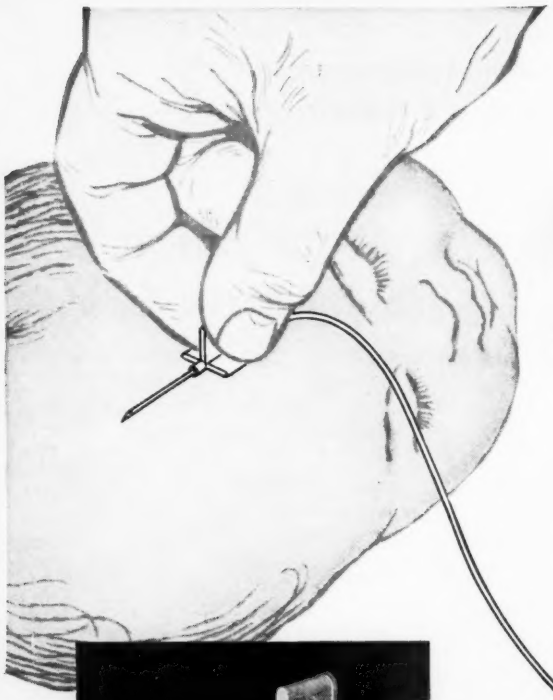

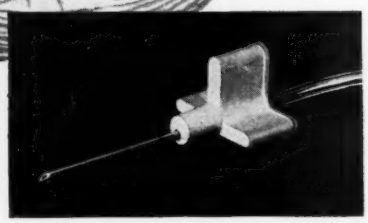

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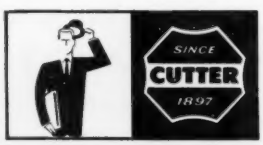

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HOSPITAL Topics OR

Official bulletin for the
Association of Operating Room Nurses

Kern County AORN Elects Officers

Mary J. Sands (seated, center), Greater Bakersfield (Calif.) Memorial Hospital, presides over the election meeting of the Kern County Association of Operating Room Nurses. She was re-elected president, having served in that post since the group was formed in 1956.

The group's new vice-president is Alma Kaufmann, West Side District Hospital, Taft, Calif.

Imogene Castle, San Joaquin Hospital, Bakersfield, was re-elected secretary, and Eva Woods, Kern General Hospital, Bakersfield, was renamed treasurer.

DeBakey, Ochsner First Speakers Announced for 1959 Congress

• Michael E. DeBakey, M.D., professor of surgery, Baylor University College of Medicine, Houston, Tex., and Alton Ochsner, M.D., professor of surgery, Tulane University School of Medicine, New Orleans, will be two of the principal speakers at the sixth national AORN congress in Houston, February 9-12, 1959.

The noted surgeons both are scheduled to lecture on the opening day of the congress.

A new feature of the 1959 meeting will be small round-table discussions on various methods and problems of sterilization. A consultant in one of each of the different methods, such as steam, dry heat, gas, and chemical disinfection, will preside at each table of 10 persons. Congress registrants will have an opportunity to sign up for the table of their choice.

The small tables will make it possible for nurses to get more detailed answers to their specific questions than if the questions were presented before a large audience.

According to present plans, 12 tables, each accommodating 10 persons and the discussion leader and a consultant, will be set up in a large room. Discussions will be conducted at all tables simultaneously, as has been done in "buzz sessions" at hospital conventions.

These sessions will be held on two and perhaps on all three days of the formal congress program, depending on the amount of interest displayed by registrants.

Further details on other program subjects and speakers will appear in the October issue of HOSPITAL TOPICS.

Discussing Outline . . .

. . . of 1959 congress program are Pauline Young, R.N. (r.), Philadelphia, national president, and Edith Dee Hall, R.N., executive secretary, at recent meeting in AORN headquarters office, New York City.

The Artificial Kidney

By Lewis W. Bluemle, Jr., M.D.*

• The artificial kidney is exactly what the name implies—a mechanical device capable of performing the excretory function of the living kidney by removing products of metabolism from the blood and body fluids. In the course of the last decade, it has become established as a valuable therapeutic tool.

The principle on which the artificial kidney operates can best be understood by reviewing the basic structure and function of the human organ after which it was patterned.

The human kidney is composed of approximately one million small, functional units called nephrons. Each unit consists of a glomerulus and a convoluted tubule. Urine formation begins at the glomerulus with the process of filtration of the blood. The blood filtrate, formed at the rate of about 100 cc. per minute, then passes through the tubule. There most of the water and essential solutes, such as glucose, sodium, and chloride, are reabsorbed into the blood stream, leaving a concentrated solution of waste products to emerge as urine at the distal end of the tubule.

A longitudinal section of a glomerular capillary, viewed under a microscope, would show that the capillary walls actually contain minute pores. These are large enough to allow the passage of tiny particles, such as molecules of urea and glucose, but not large enough to allow the passage of red cells, white cells, platelets, and protein molecules. Thus, being semipermeable, the capillary wall can act as a differential filter.

This filtration actually is a simple physical-chemical process which is not too difficult to duplicate if a similarly semipermeable artificial membrane is used. Such a membrane might be made of collodion, for example. If a series of collodion tubes were constructed, and blood passed through them, the beginning of an artificial glomerulus would be created.

If these tubes were mounted inside a glass cylinder, with appropriate manifolds at each end, and with adapters at the inlet and outlet positions, to which could be connected tubes leading to a patient's artery and vein, continuous circulation of blood through this large extracorporeal glomerulus could be established. If, however, an attempt were made to form an artificial glomerular filtrate by using the same source of energy as the human kidney, that is, blood pressure, the results would be disappointing. The artificial membrane would be so thick, as compared to the capillary wall, that tremendous pressure would be required to form even a small amount of blood filtrate. So much pressure would be needed, in fact, that the tubes would rupture.

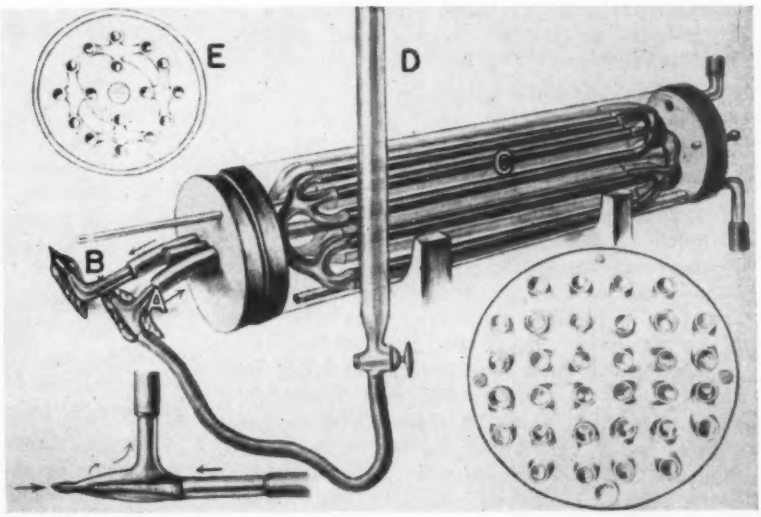
Suppose, however, that a different source of energy were employed to move blood solutes across this membrane. Suppose the energy were provided by a difference in *concentration* in the fluids on either side of the membrane. This could be achieved by bathing the tubes in water. The very fact that the blood inside the tubing would have a higher concentration of urea, for instance, than would the surrounding water, would cause a net passage of urea molecules from the blood, through the pores, into the water bath.

This is the process known as dialysis, which simply means the passage of any solute from one solution to another through a semipermeable membrane, according to the concentration gradient.

The water bath, or rinsing fluid, affords a means of removing metabolic waste products from the

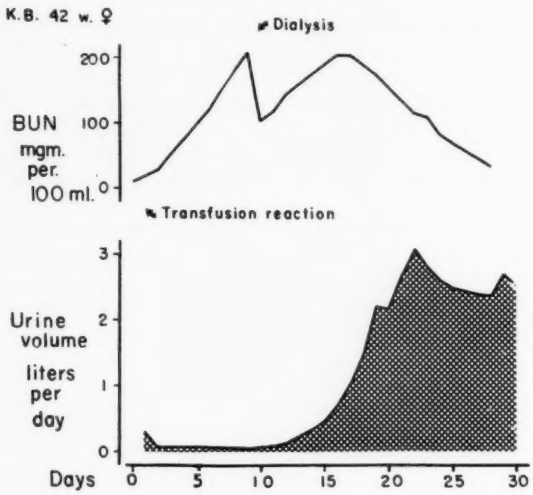
(*Continued on next page*)

*Assistant professor of medicine, University of Pennsylvania School of Medicine, Philadelphia. This article is adapted from a talk given by Dr. Bluemle at the recent fifth national congress, Association of Operating Room Nurses.



Schematic representation demonstrates principle on which artificial kidney operates. Series of tubes, composed of material simulating semipermeable membrane (inset), is encased in glass cylinder which contains water bath. Blood, taken by catheter from patient's artery, enters at point A, circulates through tubes where waste materials are removed, and leaves through point B, to be returned to patient's vein.

blood. But use of water alone poses two problems: First, the water, being hypotonic in comparison to the blood, causes hemolysis; and second, necessary constituents of the blood, such as glucose, sodium, and calcium, are lost since they, of course, dialyze out just as the urea does.



Graph demonstrates effect of dialysis on woman suffering from acute renal failure following a mismatched blood transfusion. At eighth day of reaction, blood urea nitrogen had risen to 200 mg. percent, urine output averaged about 50 cc. per day. After six-hour dialysis, blood urea nitrogen fell to 100 mg. percent; about 30 grams of urea nitrogen were removed in the process. Urine output increased gradually after dialysis with one transient episode of uremia.

Both of these problems can be solved by simply adding to the water bath enough glucose and essential electrolytes to make the concentrations on either side of the membrane approximately equal. More accurately, the concentrations of these elements in the water are equal to those of normal serum. Thus, hemolysis is prevented by provision of an isotonic bath; and the only constituents removed from the blood are the waste products, since these are the only substances which are purposely omitted from the bath fluid.

This mechanism now provides not only an artificial glomerulus, but also an artificial counterpart to the conserving mechanism of the renal tubule. In sum total, it is an artificial kidney.

Actually the first artificial kidney was a simple but ingenious device developed almost 45 years ago by Dr. John Abel, first professor of pharmacology at the Johns Hopkins University School of Medicine. He succeeded in demonstrating the potential value of the apparatus by removing salicylates from animals given test doses, but unfortunately he could not perfect his device for clinical use. The delicate collodion membranes were very difficult to make and ruptured easily, and he also lacked a good anticoagulant, and had to resort to using hirudin, a relatively poor substitute for heparin.

During the past 40 years, many improvements have been made in the basic design of the artificial kidney. Perhaps the most important development was contributed by Willem Kolff, M.D., currently of Cleveland, who did his initial work under very trying circumstances during the German occupation of Holland in World War II. Dr. Kolff developed the now famous rotating drum dialyzer, which was the first apparatus that could be used safely and effectively on human subjects.

In modification of the Kolff artificial kidney, the old collodion membranes of Abel's apparatus have been replaced with cellophane tubing, which actually is commercial sausage casing. The long tube is wound in spiral fashion around a steel drum; at either end of the tube are appropriate inlet and outlet adapters for blood. The drum is rotated in a tub of dialyzing solution; as the drum rotates, blood is propelled through the length of the tubing by the action of gravity and the principle of the Archimedes screw. The blood is taken, by catheter, from the patient's radial artery and is returned to his antecubital vein.

About 50 different designs for artificial kidneys have been developed. All of these have advantages and disadvantages. One of the most recent and most interesting developments is the disposable twin coil kidney.*

This device utilizes two parallel lengths of tubing. The tubes are bought previously sterilized, and they can be thrown away after use.

The artificial kidney used at the University of Pennsylvania Hospital employs the disposable tubing. Blood, taken from the patient's radial artery, is pumped by an atraumatic blood pump, through tubing, to the dialyzer, where it travels through the disposable tubes. After leaving the dialyzer, the blood is passed through a simple bubble trap and returned to the patient through his antecubital vein. All parts of the apparatus which come into contact with the blood have been previously sterilized.

The system is primed with banked blood before use so that at no time is more blood leaving the patient than is re-entering his circulation. The dialyzing solution is stored in large carboys; it is constantly recirculated by a turbine which forces it up through a constant temperature bath, through the appropriate chambers in the dialyzing compartment, then back through the carboys.

The artificial kidney has a number of clinical uses. It has been employed successfully to remove, from the blood, ingested poisons such as salicylates, barbiturates, or bromides. Obviously its greatest clinical application, however, is in patients with renal failure—more specifically, acute, temporary renal failure, or so-called lower nephron nephrosis.

This disease is characterized, clinically, by oliguria and severe uremia, and, pathologically, by necrosis of the renal tubular epithelium.

The primary objective of therapy in the patient with acute renal failure is to keep him in as nearly

*Manufactured by Travenol Laboratories, Morton Grove, Ill.

normal a condition as possible until he is able to regenerate new tubular epithelial cells to replace the damaged ones, after which he can again form urine. This period may last anywhere from one to three weeks. The objective can only be reached successfully by intelligent, conservative care. Such care includes the restriction of fluids and electrolytes, provision of adequate nonprotein caloric intake, prevention of infection, and, most important, good nursing care.

The artificial kidney is only an adjunct, not a substitute, for such care. Use of the device is particularly valuable as an additional measure in those patients who do not respond favorably to conservative care alone.

For example, if the patient with acute renal failure has had oliguria for eight or 10 days; is becoming increasingly comatose; and has other clinical manifestations of progressive uremia, such as twitching, convulsions, and vomiting, his chances of surviving without dialysis are considerably less than they are if he is given dialysis. This fact has been demonstrated repeatedly in patients. In a sense, dialysis provides an additional period of time for recovery from a renal injury.

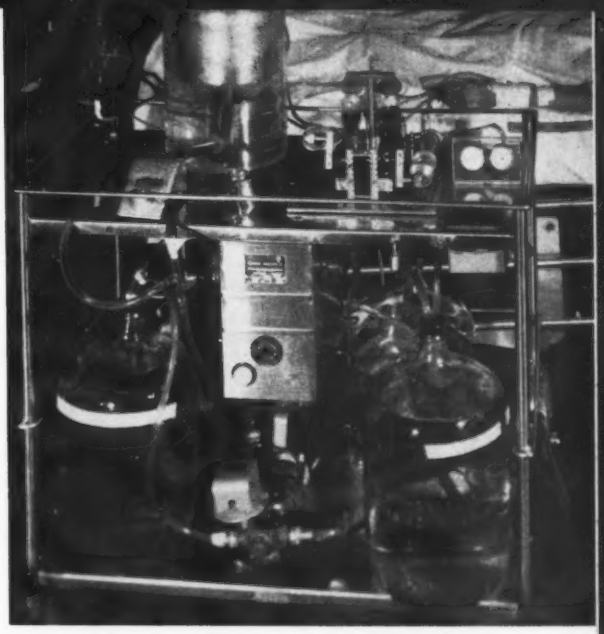
Another indication for dialysis—perhaps the most important—is potassium intoxication as a result of renal failure. Retention of potassium in body fluids leads to serious disturbances in cardiac conduction, disturbances which can progress to cardiac arrest. If the serum potassium rises above 6.5 milliequivalents per liter, at which point characteristic electrocardiographic changes usually appear, dialysis definitely should be considered.

Are there any dangers or contraindications to dialysis? Almost the only universally accepted contraindication is uncontrolled hemorrhage, particularly from the gastrointestinal tract. Heparinization, which is required by the dialysis procedure, will always accentuate such bleeding, and hence, the dialysis may cause fatal exsanguination.

Another contraindication to dialysis, to my mind at least, is hopeless uremia arising in the terminal stage of proved chronic renal disease, such as in the final stage of chronic glomerulonephritis. Suppose all possible therapeutic approaches have been exhausted, the patient has reached the relatively comfortable stage of unconsciousness, and death appears to be imminent. In such a case, I think it is highly questionable, from a moral standpoint, to use dialysis in an attempt to restore consciousness, knowing that the patient will only deteriorate again afterwards and will thus suffer through the terminal phase twice instead of just once.

I do not mean to imply that the artificial kidney is of no use in chronic renal disease. The device has been shown, for example, to be of some help in preparing for surgery the patient with chronic uremia.

It has been used with gratifying results, also, in patients with slow-moving renal failure, such as is seen in congenital polycystic renal disease, if it is given before the patient has reached the terminal phase. The primary indication for dialysis, in such a situation, is the appearance of symptoms related to uremia. After a successful dialysis, such symptoms will usually disappear and, in many patients, will not recur for as long as six months. When symptoms do recur, dialysis may be repeated.



Artificial kidney, in use at University of Pennsylvania Hospital, shows disposable tubes in position in dialyzer. Blood is drawn from patient's radial artery; atraumatic blood pump sends blood through coils wrapped around drum which is set in dialyzing solution (top of cart). Dialyzing solution is recirculated by turbine which forces it from carboy (bottom of cart), through constant temperature bath, then through drum, then back through carboy.

Another interesting application of dialysis is its use to remove excessive adema fluid by the process of ultrafiltration. It was found that this procedure could be carried out in edematous dogs if the pressure of the blood within the dialyzer was sufficiently greater than that of the dialyzing solution, and if the membrane was adequately supported to prevent its rupturing.

This procedure was utilized in one of our patients who developed pulmonary edema. A six-hour combination dialysis and ultrafiltration of the patient's blood produced a loss of a little more than one and three-quarters kilograms of body weight; an equal amount of extra water was measured in the dialyzing solution at the end of the procedure. The patient's respiratory rate, which had been elevated, fell to normal; his rales disappeared halfway through the procedure, returned briefly during a period of cardiac arrhythmia toward its end, then disappeared altogether. The patient subsequently recovered.

The artificial kidney is only one of a number of machines which have been developed to simulate the function of human organs. These machines are the first products of a fascinating and relatively new aspect of co-operative medical and engineering endeavor; their ultimate therapeutic objectives are almost limitless.

Hemodialysis for Blood Chemical Derangements

By Arthur E. MacNeill, M.D.*

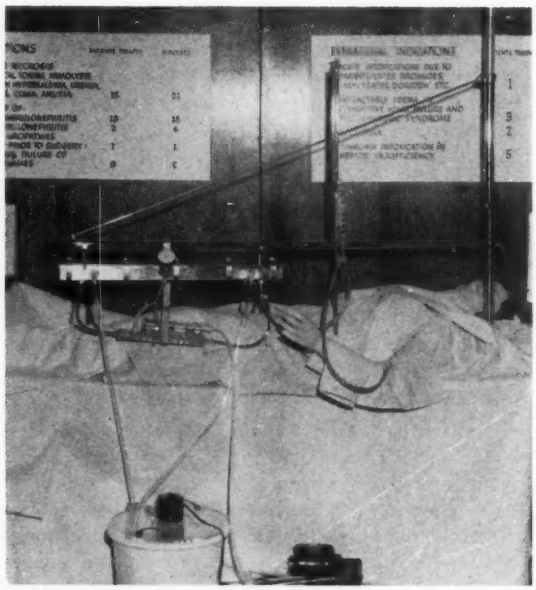
• A blood dialyzer of simplified design has been devised as part of a program for developing labor-saving apparatus for nursing personnel. Much effort has been expended to simplify details so that a bare minimum of personnel will be required for operation of the equipment and personnel can be readily trained in its use.

The design principle utilized in the MacNeill-Collins blood dialyzer† is patterned after the parallel flow arrangement of natural capillaries.

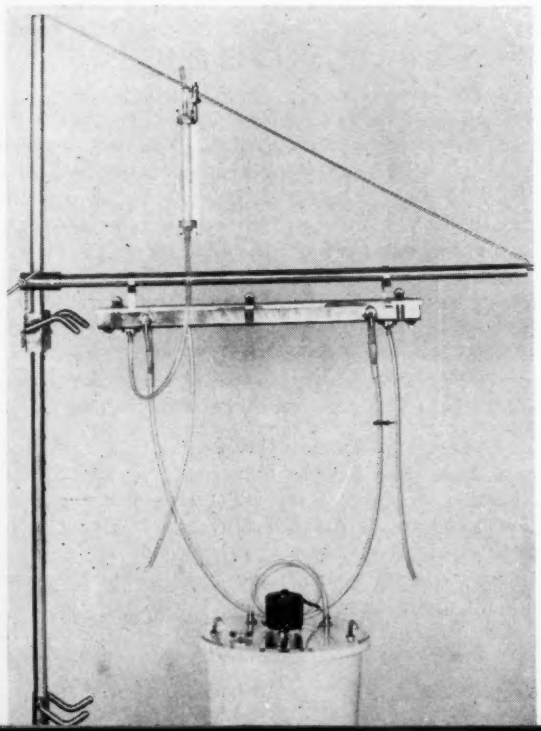
The dialyzer case is a box-like structure, slightly larger than a carton of cigarettes. Within the case, the blood is carried in parallel streams through cellophane tubes, which are flattened between nylon screens. The dialyzing bath flows through the meshwork of the nylon screens, constantly bathing the outer surface of the cellophane tubes.

The dialyzer is filled with heparinized saline before being connected to the patient. No whole blood is necessary in priming the unit. In the standard size, which contains 26 tubes, the urea clearance at a blood flow of 200 cc. per minute is 75 cc. This model of the dialyzer will usually lower a patient's blood urea nitrogen 50 percent in eight hours.

Because it utilizes a parallel flow system for the passage of the blood, the dialyzer does not necessitate a blood transfusion; when in use on a patient, the standard dialyzer contains only about 200 cc. of blood. This is a major advantage in that it reduces the danger of transfusion mishaps and also allows more prompt treatment of poisoning cases by avoiding delays for cross-matching or securing blood.



Above: Scientific exhibit at American Medical Association meeting in New York City in 1957 shows models of blood pump and dialyzer attached to dummy patient. Metal box beneath crossbar is dialyzer case containing cellophane tubes through which blood flows. White container (bottom left of picture) holds dialyzing bath. Directly beneath dialyzing case is plastic blood pump, which is powered by small electric motor (bottom right of picture).



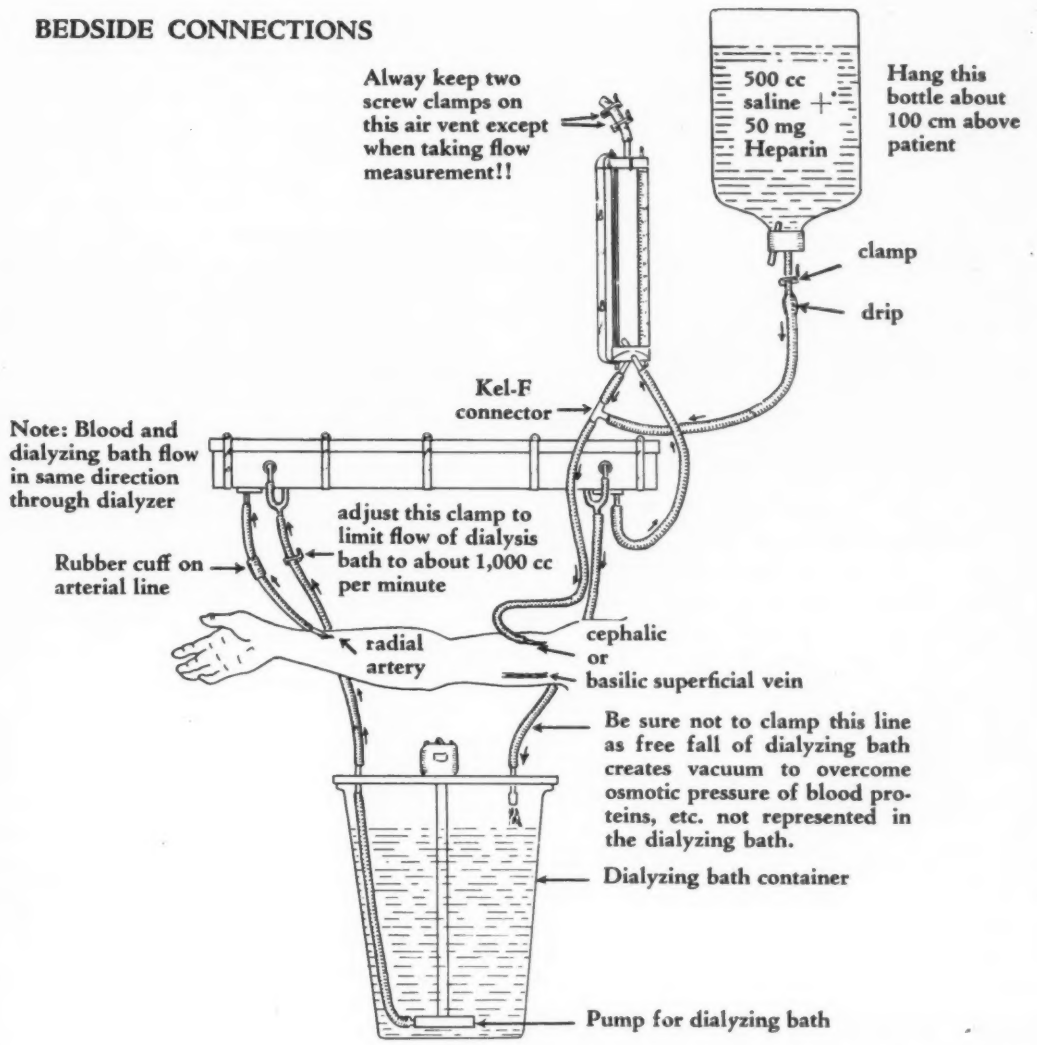
Pictured at left is standard model of MacNeill-Collins blood dialyzer; graph on opposite page demonstrates bedside connection of apparatus.

The dialyzer will operate on the patient's arterial blood pressure alone. However, the MacNeill-Collins blood pump was developed to allow use of vein-to-vein blood circuits, which provide more blood per minute than is available from most peripheral arteries. The pump broadens the application of the dialyzer, particularly in cases of heart disease. With this pump, blood has been propelled through the dialyzer circuit for from six to nine hours. Plasma hemoglobin determinations at the end of eight hours have shown insignificant hemolysis.

The pump, itself, is constructed of transparent Plexiglas inside of which are two plastic tubes. The

*Buswell research fellow and assistant research professor of surgery, University of Buffalo (N.Y.) School of Medicine; research consultant, surgical department, Buffalo General Hospital; research adviser, department of surgery, Childen's Hospital of Buffalo.

†Manufactured by Warren E. Collins, Inc., Boston, Mass.


BEDSIDE CONNECTIONS
Alway keep two screw clamps on this air vent except when taking flow measurement!!
500 cc saline + 50 mg Heparin
Hang this bottle about 100 cm above patient
clamp
drip
Kel-F connector
Note: Blood and dialyzing bath flow in same direction through dialyzer
adjust this clamp to limit flow of dialysis bath to about 1,000 cc per minute
Rubber cuff on arterial line
radial artery
cephalic or basilic superficial vein
Be sure not to clamp this line as free fall of dialyzing bath creates vacuum to overcome osmotic pressure of blood proteins, etc. not represented in the dialyzing bath.
Dialyzing bath container
Pump for dialyzing bath

top tube, closed at one end, receives the alternating suction and pressure delivered by the pulser, or pumping mechanism. The lower tube, open at both ends, receives the blood from the patient, pumps it through the dialyzer, then returns it to the patient. The pumping medium is a 0.9 percent sterile saline solution.

The pulser is a small, motor-driven air piston. Although electrically powered, the motor can be hand-cranked in an emergency, eliminating special demands on the electrical supply.

Renal indications for use of the dialyzer include acute tubular necrosis caused by such factors as chemical toxins, hemolysis, or shock, and accompanied by hyperkalemia, uremia, severe acidosis, coma, and anuria; and selected cases of chronic or acute glomerulonephritis, obstructive uropathies, or chronic renal failure from other causes.

Extrarenal indications are: acute drug intoxication, such as that caused by barbiturates, bromides, or salicylates; intractable edema in patients with congestive heart failure or nephrotic syndrome; eclampsia; and ammonia intoxication in hepatic insufficiency.

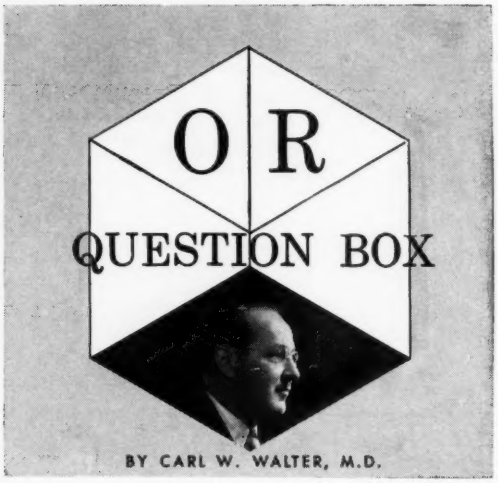
Several advantages of the equipment are of special interest to operating-room personnel. These include the following features:

——The entire blood pathway can be sterilized by autoclaving in a standard manner. Blood tubes are short and can be discarded rather than cleaned. The entire apparatus can be disassembled, cleaned, and reassembled in a relatively short period of time.

——Special blood-line access tubes allow blood samples to be taken without syringes or needles, decreasing demands on both O.R. and central supply room personnel.

——The treatment can be administered in any room in which a sink is available. Thus, the patient need not be taken to the operating room, upsetting normal O.R. schedules with the procedure.

——The apparatus is compact, lightweight, and portable, and requires only a modest space for storage.



Assisted by Dorothy W. Errera, R.N.

Q. Should tonsil suction tubing be sterile? If so, how do you recommend sterilizing it? For the last 15 years I have been working in operating rooms. I have been taught that the mouth is not a sterile field. Therefore, I thought it was sufficient to wash tubing well with G-11 and wipe with alcohol the end that goes over the drape.

A. The mouth is indeed an unsterile field. A wide range of bacterial contaminants resides in the mouth and nasopharynx. To prevent cross-infection among patients and personnel, terminal disinfection of instruments used in the mouth is imperative. Cleaning such as you describe removes gross soil but provides no factor of safety, either for subsequent patients or personnel handling the contaminated tubing.

Rubber and heat-stable plastic suction tubing is available, and it is no burden to provide each patient with a length of sterile suction tubing. If properly handled, rubber tubing will withstand repeated exposure to saturated steam at 250° F. without losing its rigidity.

Q. The problem of cleaning anesthesia equipment, particularly anesthesia machines used in tubercular cases, is a great one. Often one anesthesia machine is set aside for use in the tuberculosis operating room, but then the problem arises as to how to clean this machine between successive cases on the same day. I will appreciate your opinions as to what our attitudes and practices should be toward anesthesia equipment and machines in such situations.

A. The problem in disinfection of anesthesia apparatus is limited to parts actually exposed to bacteria from the patient's nasopharynx—masks, tubing, rebreathing apparatus, etc. The machine itself need not be considered contaminated unless actually splattered with sputum, blood, or pus.

The emphasis in terminal disinfection is on avoiding the spread of organisms from one patient to another or to operating room personnel. This implies disposal of contaminated material at the point of use. Nothing is accomplished if such material is transported through an operating suite, shedding organisms en route, and then left to accumulate for a convenient clean-up time. Personnel must be rigid in the use of gown and gloves when handling contaminated material or when threatened with splashing from such material.

The ethylene-oxide sterilizer provides ideal facilities for terminal sterilization of the bits of anesthesia equipment that will not withstand exposure to the ordinary steam sterilizer. The low temperatures used in the former are compatible with the poor heat-tolerance characteristic of rubber.

When anesthesia is discontinued, the potentially contaminated parts can be disposed of directly into a clean towel and placed directly in the sterilizer for terminal disinfection. If an ethylene-oxide sterilizer is not available, chemical disinfection must be relied upon. Few germicides destroy the *Mycobacterium tuberculosis*. Among the effective ones are:

Ethyl alcohol-70%
Isopropyl alcohol-70%
Cresol solution saponated USP XIII
Orthophenyl phenol
Arylphenolics 2%
Iodophors 75 p.p.m.

At the end of each case, the contaminated parts are dropped into a solution of any of the above and left immersed for 15 minutes. At the end of this time, they are safe for general cleaning.

If any part of the anesthesia machine is actually contaminated, it is cleaned as are other potentially contaminated bits of furniture in the room, with any of the agents listed above.

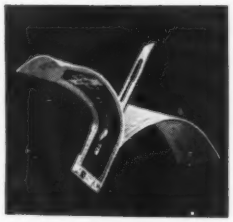
Q. I would appreciate information on sterilizing portions of the heart-lung apparatus such as the lucite containers, lids, and Tygon tubing.

A. Heart-lung apparatus can be sterilized satisfactorily after being completely assembled by simply flooding the fluid passages with a two percent saline solution of ethylene oxide. To accomplish this, the heart lung apparatus must be chilled to 5° C. in a refrigerator. The ethylene-oxide bottle must also be chilled to 5° C., as must the flask of saline and all the equipment used to handle the liquid ethylene oxide.

Sufficient ethylene oxide is measured into the saline solution to make a two percent concentration. The biomechanical apparatus is then filled with the solution and the ends of the tubing closed tightly. The equipment is allowed to come to room temperature. It can be considered sterile after six hours' exposure. The apparatus is put into use by washing out the ethylene-oxide solution with sterile saline prior to priming the equipment with blood.

What every O.R. Nurse should know about A·S·R STERISHARP blades

Q. *What is a SteriSharp?*



A. It is a sterile-packed surgical blade made from a special alloy of extremely hard stainless steel. Like all stainless-steel surgical instruments it will not rust or corrode in hospital use.

Q. *Aren't all sterile-packed blades made from stainless steel?*

A. No, only SteriSharps. All others are made from ordinary carbon steel which rusts, corrodes and dulls quickly when autoclaved or kept in solution.

Q. *Are SteriSharp blades sharper than carbon steel blades?*

A. Yes. SteriSharps' imported high-chrome alloy Swedish steel is hardened, tempered, ground and sharpened under processes developed by A·S·R to give it a sharper, longer lasting cutting edge.

Q. *Can I autoclave the sealed SteriSharp packet?*

A. Yes. Neither autoclaving nor dry-heat sterilizing harms the packet or the blade inside. This means you can include any number of SteriSharp packets on the instrument tray. The sterile nurse can then open blades as needed. And all unopened packets can be returned to stock.

Q. *Can I autoclave SteriSharp blades out of the packet?*

A. Yes. Unlike carbon steel blades which blacken, rust and lose their edge when autoclaved, SteriSharp blades can be autoclaved repeatedly without damage. Thus, SteriSharps which have been opened but not used can be returned to stock. This eliminates blade waste. SteriSharps can be stored indefinitely without harm.

Q. *How does A·S·R make sure that SteriSharps are 100% sterile?*

A. SteriSharps are ultrasonically cleaned before packaging. The packets are sealed securely and are heat-sterilized at a time-and-temperature cycle well above highest hospital requirements. Each lot is sampled *twice*, and blades are tested for sterility by A·S·R's own bacteriologists according to USP XV (revised). Each lot is also checked by an independent laboratory.

Q. *How can I be sure SteriSharps come to me 100% sterile?*

A. Test them in your own laboratory. We will be happy to send you a detailed description of our sterility testing methods.

Q. *Can SteriSharps be re-used?*

A. After their work in the Operating Room, SteriSharps can be autoclaved and distributed to Pathology and other blade-using departments.

Q. *How do SteriSharps compare in cost with other sterile-packed blades?*

A. SteriSharps cost less.

Q. *How do SteriSharps compare in cost with ordinary carbon steel blades?*

A. SteriSharps do away with jars and solutions and eliminate blade waste. In addition, the greater durability of stainless steel means longer blade life. Surgeons report that during procedures where extensive cutting is required, one SteriSharp does the work of as many as six ordinary carbon steel blades. Hospitals using SteriSharps report dollar savings of 25% and more over conventional nonsterile carbon blades.

Q. *Do SteriSharps come in all standard sizes and fit all standard handles?*

A. Yes. In addition, when you contract for SteriSharps, you will receive FREE as many stainless-steel dispensers as you need for your O.R. suite and other blade-using departments.

Q. *How can I find out more about SteriSharps?*

A. Write: A·S·R HOSPITAL DIVISION, DEPT. HT, 380 MADISON AVENUE, NEW YORK 17, N. Y.

In Canada—A·S·R HOSPITAL DIVISION, 2055 DESJARDINS AVENUE, MONTREAL, CANADA

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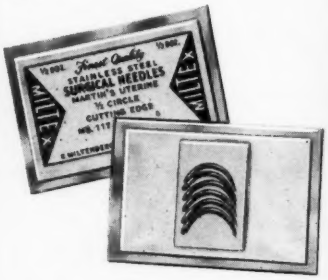

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SELECTED BIBLIOGRAPHY

By Dorothy W. Errera, R.N.

Suggestions will be welcomed for subjects to be covered in future issues.—The EDITORS.

Borden, Fred W.: "Loss of Blood at Operation. A Method for Continuous Measurement." *Calif. Med.* 87:91, Aug., 1957.

A technic for continuous measurement of surgical blood loss is described. The instrument used has three parts—a volumetric device for automatically measuring blood collected by suction, auxiliary suction bottles to receive other liquids collected by suction, and a gravimetric device for measuring blood in sponges and drapes.

Calculation and conversion are eliminated by the use of a spring balance with two specially graduated scales. One, which rotates, is read directly in cc. of blood. The other is stationary and concentric to the first and is graduated to indicate the number and kind of sponges being weighed. When a batch of soiled sponges is deposited in the weighing pan, the arm indicator is moved to signify the number of sponges, and the dry weight of the sponges is automatically deducted from their gross weight. The dial scale then indicates the net volume of blood in the sponges.

A special surgical suction tube which incorporates a self-rinsing mechanism is used when blood is aspirated from the field. The intricasies of measuring blood loss through the aspirating conduit are described in detail, and time and motion factors are evaluated.

Denson, J. S., Joseph, S. I., Koons, R. A., Murry, W. C., and Bissonnette, H. W.: "Effects of Detergents Intrathecally." "Current Comments and Case Reports," *Anesthesiology* 18:143, Jan-Feb., 1957.

The effects of residual contaminants on equipment used for spinal anesthesia have been well documented. In this small series, the authors attempt to evaluate the role of residual detergents on this equipment.

In the stress of operating room routine, certain laxities inevitably develop, one of which is inadequate rinsing of washed equipment. In this study, five Javanese macaque monkeys were induced with intraperitoneal Nembutal, and spinal anesthesia was administered using syringes which had been soaked in various detergent solutions for one hour and sterilized without rinsing.

Animals were observed for six to 14 months. One animal became clinically paraplegic four months after his first anesthesia. The other four appeared clinically normal, but at autopsy, the spinal cords and their investments in all the animals showed arachnoiditis and nerve tissue damage.

To All National AORN Members Not Affiliated with a Unit

Elections for the following offices will be held at the annual congress, Association of Operating Room Nurses, in Houston, February 9-12, 1959:

President
Treasurer
Two board members
Three nominating committee members.

A nominee for any of these offices must have the following qualifications:

1. She must have been a national AORN member in 1957, and must be a member in good standing for the current year.

2. She must be a member of the American Nurses' Association.

3. She must have held one term of office in a local AORN group.

4. She must be certain of her availability for national board meetings.

A biographical sketch of each nominee should be submitted. A photograph must be submitted if the nominee is selected for the ballot.

Every national AORN member not affiliated with a local unit is invited to submit one name for each of the offices mentioned, along with a biographical sketch of each person.

The by-laws of the association state that no elected officer shall serve more than two consecutive terms in the same office. The first officers were elected in 1957 for two and three-year terms, and therefore are eligible for renomination and re-election. Present officers and expiration dates of their terms are:

President—Pauline R. Young, O.R.S., Hahnemann Medical College and Hospital, Philadelphia (1959).

Vice-president—Frances E. Reeser, O.R.S., VA Hospital, Bronx, N. Y. (1960).

Recording secretary—Mrs. Mary E. Kreitz, O.R.S., Kaiser Foundation Hospital, Los Angeles (1960).

Treasurer—Mrs. Anne Dodge Sasse, R.N., New York City (1959).

Board of directors: Sister Alexine, O.R.S., Mercy Hospital, San Diego, Calif. (1960); Mrs. Ethel I. West, O.R.S., Methodist Hospital of Southern California, Arcadia (1960); Mrs. Joan Driscoll, O.R.S., Westchester Square Hospital, New York City (1960); Ruth Pendleton, R.N., director of the operating room, New England Deaconess Hospital, Boston (filling unexpired term of the late Mrs. Evelyn Ellsworth) (1959); Mrs. Doris Walk, R.N., St. Louis (1959).

Nominating committee: Mrs. Doris Deimel, O.R.S., Rockaway Beach (N.Y.) Hospital, chairman (1959); Marilyn Dentino, R.N., staff nurse, operating room, Mercy Hospital, Denver, Colo. (1959); and Gertrude Payne, O.R.S., St. Elizabeth Hospital, Washington, D. C. (1959).

In order that every nominee may be given due consideration, the names should be submitted to the chairman of the national nominating committee no later than October 1, 1958.

Mrs. Doris Deimel, R.N., Chairman
National Nominating Committee
32 Hampshire Road
Rockville Centre, N. Y.

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• The "problem clinic," a popular session at every national AORN congress, was divided at the 1958 congress into two meetings—one for small hospitals (15 to 75 beds) and one for average and large hospitals. Questions from both these panel discussions have been selected to appear in this column. This month's questions were taken from the session for average and large hospitals.

PANEL: *Dean Theresa I. Lynch*, School of Nursing, University of Pennsylvania Hospital, Philadelphia, moderator.

L. Kraeer Ferguson, M.D., professor of surgery, Woman's Medical College of Pennsylvania and University of Pennsylvania Graduate School of Medicine.

Charles S. Paxson, Jr., administrator, Hahnemann Medical College and Hospital, Philadelphia.

Edward T. Lawless, M.D., anesthesiologist, St. Joseph's Hospital, Paterson, N. J.

Dorothy L. Hufcut, R.N., chief, nursing service, VA Hospital, Wilmington, Del.

Mary Jane Venger, R.N., director of nursing, Albert Einstein Medical Center, Philadelphia.

Sister Mary Albina, O.R.S., St. Agnes Hospital, Philadelphia.

Mrs. Doris Deimel, O.R.S., Rockaway Beach (N.Y.) Hospital.

Mrs. Lillian Sholtis Brunner, R.N., consultant in medical and surgical nursing, Bryn Mawr (Pa.) Hospital School of Nursing.

Q. How can we stop our doctors from coming into the operating room in street clothes, and even with a cigarette, Dr. Ferguson?

DR. FERGUSON: How you're going to stop them, I think, depends on the local rules and regulations. I believe the operating-room supervisor is really the one who has to guard her precinct, so to speak. There is no group of people worse than surgeons about being told what they should and shouldn't do.

On the other hand, I think they're a relatively reasonable group, too. Whether they will be anxious to do what the supervisor says, or whether they will be a little rebellious, depends somewhat on how they're told.

I'm sure there isn't a single surgeon who wouldn't feel very bad if he thought that by walking into an operating room in his street clothes, and smoking a cigarette, he would endanger the patient and interrupt operations.

A surgeon usually commits these infractions, not because he is trying to transgress from established, reasonable rules, but because he has something on his mind which he thinks is important and has to be done at that time and he can't have it done if he has to change his clothes.

There should be a happy medium, of course, and the O.R. supervisor should be the one to bring it about. I think a word or two, nicely placed, nicely said, calling attention to transgressions, will in short time remedy these transgressions.

One other point: I think it is very bad to have an operating-room supervisor who is so rigid, so absolutely unbending about technic and what not, that there can *never* be a slip—and perhaps never very good relationships in the operating room, either.

MRS. BRUNNER: I think the physical set-up of the operating room is a very important factor. If there is a doctors' lounge outside the department, there probably will not be as much difficulty with this problem.

DR. LAWLESS: I think it's *everybody's* responsibility in an operating room to correct any infraction of rules and regulations laid down for the operating room—whether it's the wearing of street clothes, or breaking of sterile technics.

Any time an infraction is seen by any person in the operating room, whether it be the operating-room supervisor or a student nurse, the anesthesiologist, a surgeon, or even one of the aides, the attention of the offender should be called to it immediately, loudly, and in no uncertain terms.

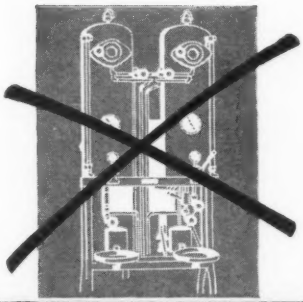
If this attitude is adopted, I think in a very short time the operating room will be run with a minimum number of infractions of rules.

Q. To whom should the operating-room supervisor be responsible—to the chief of surgery, the director of nurses, or the hospital administrator?

DR. FERGUSON: I believe the operating-room supervisor should report to the director of nurses. She is an integral part of the nursing service.

However, I don't see how you can separate the operating-room supervisor from the surgeon, or the surgical staff, or an operating-room committee, or some such

(Continued on page 128)



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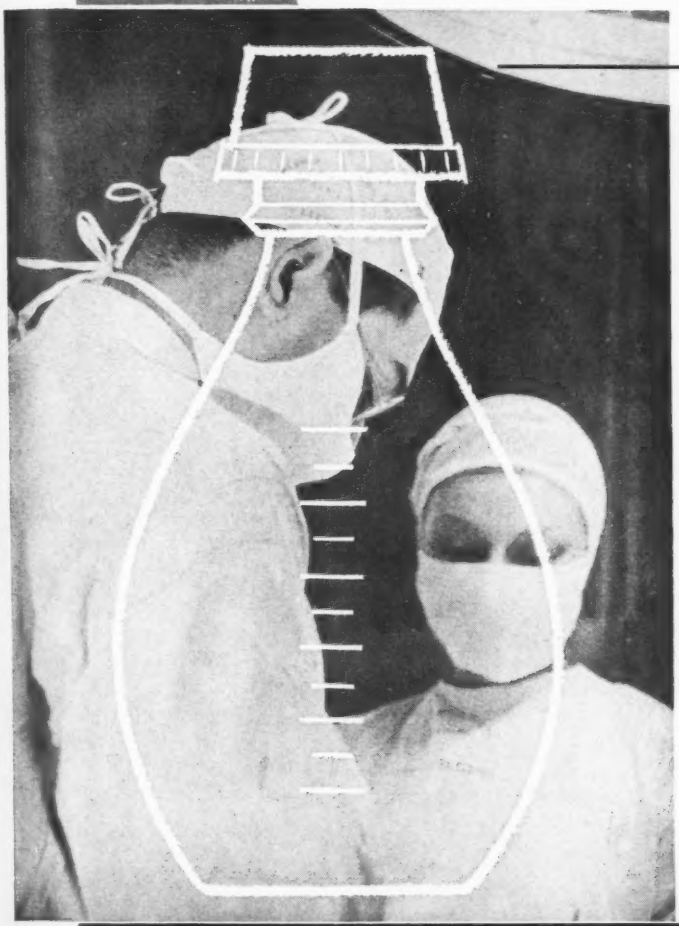

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Dr. Walter to Present Institute in London

The first operating-room institute to be presented in England by Carl W. Walter, M.D., will be given September 22-27, at St. Bartholomew's Hospital, London.

Dr. Walter, associate clinical professor of surgery, Harvard Medical School, and a surgeon at Peter Bent Brigham Hospital, Boston, will be assisted by Mrs. Dorothy W. Errera, R.N.

The institute is being sponsored by the Royal College of Surgeons, the Royal College of Nursing, and the London Hospital Council.

Material presented will include information on operating-room design and technics; methods of sterilization; central supply room design, organization, and technics; parenteral therapy, blood-bank technics, and explosion hazards in the operating room.

PROBLEM CLINIC

(Continued from page 126)

group. The operating-room committee or the chief of surgery, or whoever is supposed to head up the operating room, has to have some say in her activities too.

As far as the operating room itself is concerned, I think the operating-room committee, which sets up policy, should include the operating-room supervisor, and the supervisor should be delegated to carry out the wishes and rules of that committee.

MR. PAXSON: I feel that all of our nursing problems should go through the director of nurses. But I also feel, that in the table of organization there should be a path, not only to the director of nurses, but to the administrator.

The operating-room committee can be very helpful. On the floors the nurses work directly under a physician's guidance. In the operating room they really work under the guidance of a team of physicians. Guidance is a committee proposition. I believe disciplinary problems also resolve themselves to the degree the operating-room committee is active and vocal, advertising the requirements and the infractions. The committee removes the onus from the operating-room supervisor.

The committee should include one or two surgeons; the anesthesiologist; the director of nurses; the operating-room supervisor, and the administrator. Professional policies are established by the committee, and of course the O.R. supervisor carries them out.

Q. Should this committee be a policy-making group, or only advisory?

MISS VENGER: I think it should probably be both. Certainly policies need to be set down for the operating room, on such matters as what doctors are going to do and what other members of the staff are going to do if they go to the operating room for any reason. Suppose the administrator is a doctor, and is not a member of the hospital's surgical staff — yet decides he wants to operate? Is he going to be permitted to or not?

All these things need to be taken up, along with such problems as infractions of the smoking regulations, and what the staff member will wear when he goes to or leaves the operating room.

I think it's equally important for us to be concerned about whether the members of the operating-room—surgeons or nurses—wander all over the hospital in their O.R. garb. Not only is this practice bad technic, but also it is very bad from the standpoint of the patient who observes it. I don't think patients appreciate it; I don't think I would if I were a patient.

It is very important that the committee set down the regulations and disseminate them and let it be known that there are doctors and other members of the staff on the committee, so that no one group will be blamed for having made the rules.

MR. PAXSON: On certain things the committee should establish policy; then the administration should see that policies are enforced. In other areas the committee's function is advisory. If said, "We need a new operating suite," I'd want that to come as advice.

Army Students Receive Residency Assignments

Twenty-eight students in hospital administration at the Army Medical Service School, Brooke Army Medical Center, Fort Sam Houston, Tex., have been given residency assignments as part of their work toward a Master's degree in hospital administration.

Army degree candidates and their residencies are these: Lt. Col. Murray F. Evans, Maj. Rubye W. Archer (ANC), Maj. Vernon E. Case, and Maj. Floyd E. Van Sickle, Brooke Army Medical Center; Lt. Col. Wade F. Hampton and Maj. Joseph C. Burgio, Valley Forge Army Hospital, Phoenixville, Pa.; Lt. Col. Robert F. Lerg and Lt. Col. John A. Mikuluk, Walter Reed Army Medical Center, Washington, D.C.

Capt. John Atkins, DeWitt Army Hospital, Fort Belvoir, Va.; Maj. Rita A. Cleveland (ANC), Germany; Lt. Col. Julian J. Fried (MC), U.S. Army Hospital, Dugway (Utah) Proving Grounds; Maj. Matthew Ginalick, Madigan Army Hospital, Tacoma, Wash.; Maj. Hugo K. Koch, William Beaumont Army Hospital, El Paso, Tex.; Lt. Col. James E. Lewis (MC), Ankara, Turkey; Maj. Edward M. Strobel, Fitzsimmons Army Hospital, Denver; Capt. Frank S. Tarantino, Letterman Army Hospital, San Francisco; Maj. Helen J. Thornburg (ANC), Ireland Army Hospital, Fort Knox, Ky.; Capt. Eileen B. Witte (AMSC), U.S. Army Hospital, Fort Jay, N.Y.

Air Force Medical Service Corps officers and their assignments are: Maj. William S. Beck, Columbus (Miss.) AFB Hospital; Capt. James B. Culbertson, Greenland; Capt. Harold Diehl, Jr., Hamilton (Calif.) AFB Hospital; Capt. Robert A. Watson, 1st Lt. Dean S. Holman, and 1st Lt. Carlos A. Soto, Air Force Institute of Technology, Wright-Patterson AFB, Dayton, O.; Capt. Albert M. Meyer and 1st Lt. Richard E. Woodruff, Germany.

Two allied medical officers who are degree candidates are Col. Ali Permoun, Iran, and Lt. Col. Agha Fakhar Hussain, Pakistan. Others in the class from foreign countries include: 1st Lt. Joaquin R. Carvajal (Inf), Colombia; Lt. Col. Lee Kiyoon, Korea; Col. Wang Tze Peung (MC), Taiwan, and Maj. Frederick S. W. Whittington (RCAMC), Canada.

Other officers in the 1958 class and their assignments are: Maj. Martin J. Carr, Germany; Maj. Dave C. Clark, Panama; Maj. Dudley P. Cook, Germany; Maj. Jordan L. Epperson, Korea; Maj. Jack L. Flora, France; Lt. Col. Chris D. Hoover, U.S. Army Hospital, Fort Carson, Colo.; Maj. Kenneth G. Howard, Tripler Army Hospital, Hawaii; and Lt. Col. Orne D. Smith, U.S. Army Hospital, Fort McPherson, Ga.

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d. Purchasing Agent. East. 500-bed hospital (H-2229).
e. Accountant. Travel for hospital management company checking member hospitals (H-2174).

PHARMACISTS:

a. Chief. University medical center. Will institute a hospital pharmacy internship program in near future. Require Masters' Degree; to $7,500 (HT-1910).
b. South. 400-bed hospital in metropolitan community. $5,700 (HT-1454).
c. Chief. Middle West. 250-bed hospital, near Chicago. $6,000 (HT-1577).
d. Staff. East. 350-bed hospital; some manufacturing. $5,700 (HT-1662).
e. Assistant. South. 250-bed hospital in medical center with two universities. $5,400 (HT-1903).

DIRECTOR OF NURSING:

a. California. 100-bed hospital near Los Angeles. Degree plus some hospital experience. $6,600 (HT-2329).
b. East. 200-bed hospital. B.S. degree, 50 to 60 in school. $8,000 (HT-1960).
c. Director, Nursing Service. 220-bed hospital affiliated with university. $7,500 (HT-1778).
d. South. 325-bed hospital in city of 60,000. $7,200 (HT-2281).

NURSE ANESTHETISTS:

a. East. New 220-bed hospital. Favorable working schedule. $525 (HT-2023).
b. Middle West. 150-bed hospital. $600 (HT-2008).
c. Southwest. 40-bed hospital in resort area. $500 (HT-1297).
d. South. 100-bed hospital opened in 1957. Two in department. $650 (HT-813).
e. Southwest. Free-lance anesthesia with another anesthetist. Excellent opportunity. (HT-2305).

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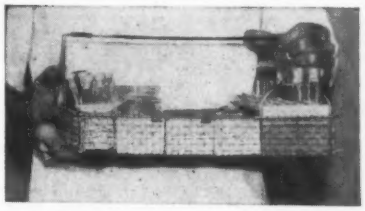
Everyone



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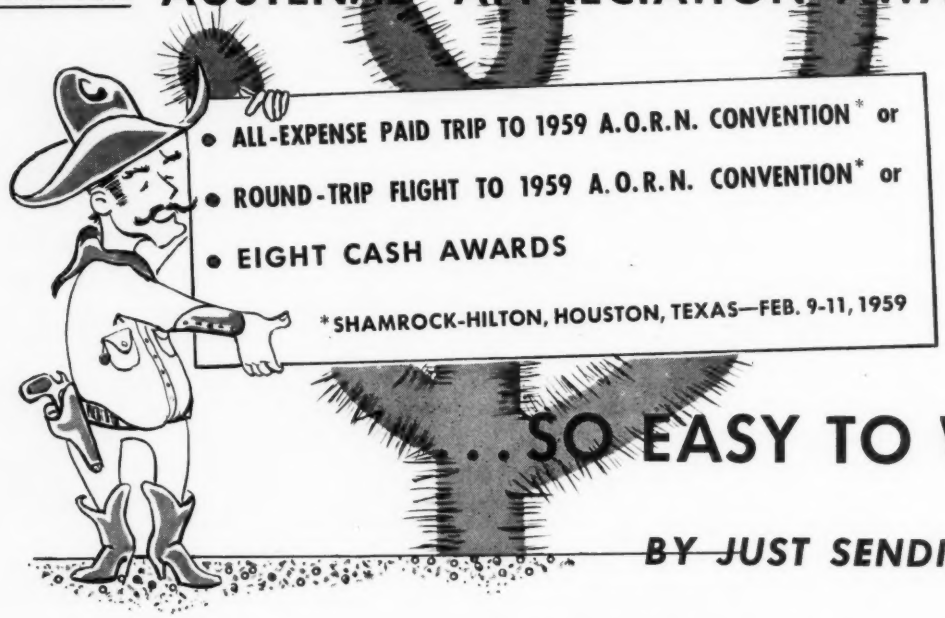
• ALL-EXPENSE PAID TRIP TO 1959 A.O.R.N. CONVENTION* or
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*SHAMROCK-HILTON, HOUSTON, TEXAS—FEB. 9-11, 1959

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OFFICIAL RULES

1. Only actively-employed Operating Room Supervisors and Operating Room Nurses are eligible for Austenal Appreciation Awards.

2. All entries will be judged on *originality* and *practicability* of suggestions or ideas concerning the use, handling, storing or packaging of Vitallium Surgical Appliances and Instruments. The best suggestions, in the opinion of the judges, win.

3. All entries should be legible and include: name, home address, phone number, and hospital where employed, on each page submitted.

4. Address entries to: Surgical Division, Austenal, Inc., 224 E. 39th St., New York, N.Y. All entries must be postmarked prior to midnight, November 15, 1958.

5. All entries will be judged by the Awards Panel. They are: Miss Pauline Young, R.N., President, AORN, ORS, Hahnemann Hospital, Philadelphia; Miss Edith Dee Hall, R.N., Exec. Secretary, AORN; Miss Hazel Evans, R.N., ORS, Hospital For Special Surgery, New York; Miss Ruth Schmidt, R.N., ORS, Presbyterian Hospital, Chicago; J. H. Begert, Austenal, Inc.

6. The awards are: *First*—All-expense paid trip to 1959 AORN Convention, Houston, Texas; *Second*—Round trip flight to 1959 AORN Convention; *Third*—Cash award of $100.00; *Fourth, Fifth*—Cash awards of $75.00 each; *Sixth* thru *Tenth*—Cash awards of $50.00 each. All winners will be notified by December 15, 1958.

7. All entries become the property of Austenal, Inc. and the decision of the judges is final.

AUSTENAL, INC. *Surgical* DIVISION

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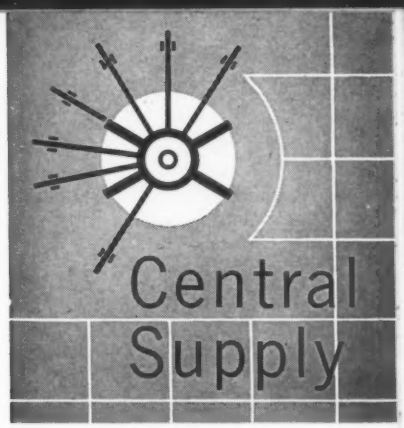
How Our Laundry Washes, Wraps Gloves and Surgical Packs



By Charles B. Cook*

• For 10 years gloves have been washed, dried, and packaged in the laundry at the University of California Medical Center, San Francisco, and for the last three years surgical and obstetrical packs have been assembled in the laundry.

Both the hospital administration and the nursing staff are very satisfied with the performance of these procedures in the laundry. It has these definite advantages:

1. Centralized supervision.

2. Use of cheaper space for these activities, instead of more valuable space in the hospital building itself.

3. More effective utilization of personnel. Laundry personnel assigned to assembling packs are kept busy all the time, because they can be used in other laundry operations when they are not working on packs. (Personnel assigned to the glove room are kept busy there full time, turning out an average of 900-1,000 pairs of gloves a day.)

4. A real saving of time, and therefore of money as well, in the washing of gloves, because washing is done only once a day. If an automatic washer of the type used in homes were employed for washing gloves, several loads a day would be necessary to wash the quantity of gloves used in our hospital.

The University of California Hospital is now a 470-bed institution. Eventually, when units under construction are opened, the medical center will include close to 1,000 beds. There are 10 major operating rooms, 30 maternity beds, and 40 nursery cribs. At present the quantities of packs and gloves prepared daily by the laundry are:

Gloves—900-1,000 pairs

Surgical packs—40 major packs

Obstetrical packs—20

Diapers—approximately 1,200 for the nursery alone.

In our opinion, any hospital with a laundry should have the laundry wash rubber gloves. A small hospital which does not have a laundry of course does not have the volume that a larger hospital has, and can therefore use the home-type automatic washer, probably in the central supply department.

When we were developing our method for washing and drying gloves, the deleterious effect of heat was thoroughly considered. After research on bleaches and alkalies, we found that the only harmful ingredient was alkali, and that the operations employed by the laundry in handling rubber gloves were not harmful. We decided to use a mild synthetic soap with a low percentage of detergent, because the superficial dirt on the gloves was easily removed by the mild soap.

GLOVE CARE ON FLOORS

After gloves are used on the floors, they are rinsed under cold, then hot, running water and placed in a bucket provided for them. They are picked up by central supply personnel on the department's regular pick-up and delivery rounds. Gloves are sent from the central supply department to the laundry several times a day, but washing of gloves is done only once a day—usually in the morning.

WASHING

Gloves are washed in a pony washer, in lukewarm water—80°-90°. Dissolved synthetic soap is added to about 10" of water. Care is taken not to raise suds. Gloves are washed for about eight minutes.

Hard water is better for washing. Zeolite-softened water, especially, is charged, and the water softens rubber.

The next step is rinsing. Gloves are given at least six two-minute split rinses in 12" to 14" of water at not more than 60° to 80°.

Adding one cup of ½ of one percent bleach to the first and last rinse helps to eliminate sticking of gloves.

Nets are not used. We do not believe that gloves in bags get the full benefit of the rinses.

DRYING

When gloves are removed from the washer, they are placed in metal trucks to drain. Then they are put in a 36 x 30 drying tumbler, and dried for about an hour and 15 minutes—first for 20 minutes in cold air, then for the remainder of the time in a mixture of half hot and half cold air. The temperature is kept below 180°.

These precautions should be observed to obtain the most satisfactory results:

1. Do not use water over lukewarm temperature.

2. Do not use nets for washing.

3. Use a mild synthetic soap. At no time have apparent suds. The use of too much soap will be the greatest problem.

4. Never wash or rinse gloves in low water. Suspension and floating in high water gives better results.

5. Do not use an extractor.

(Continued on next page)

*Superintendent of general services, University of California Medical Center, San Francisco.

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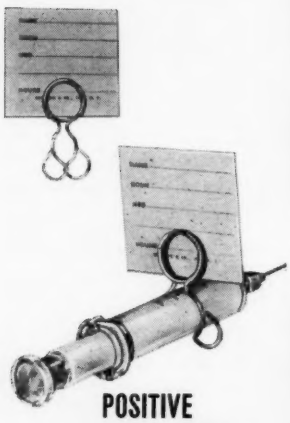

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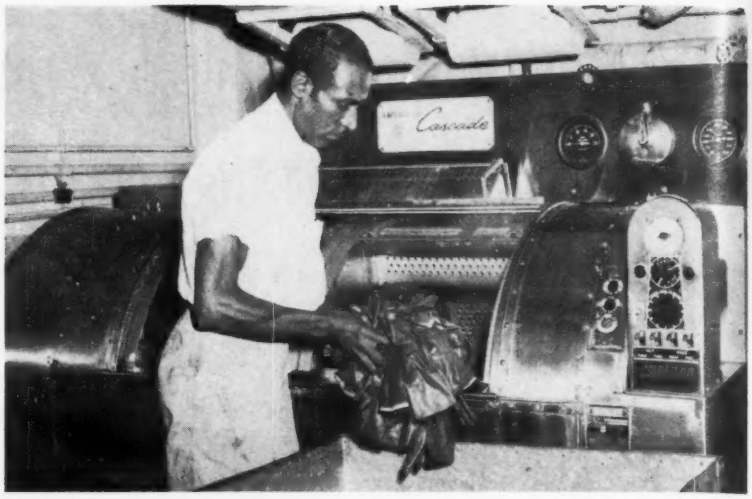


Thomas Guerry removes gloves from the washer in the laundry. They are placed in metal trucks to drain.

Fred Danzeler puts gloves in tumbler for drying. They are dried for about an hour and 15 minutes—first for 20 minutes in cold air, then for the remainder of time in a mixture of half hot and half cold air.

Margaret Richard tests gloves before they are packaged. Left gloves go into bins on her left; right gloves into bins on her right. Defective ones are discarded. Tester—adapted from a commercially available mechanism—is plugged into the hospital's compressed air line.

Dorothy Lincoln takes gloves out of the powdering machine. She wears a mask to protect her nose and throat passages from irritation by the powder.

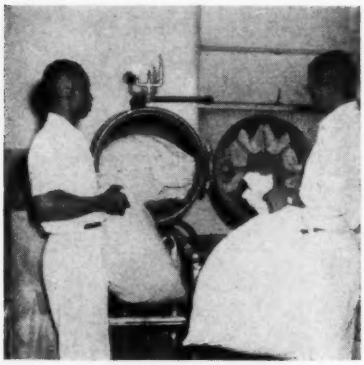
(Continued on next page)

Above: Dorothy Lincoln and Margaret Richard package rectal gloves, using standard muslin wrap. Right: Miss Richard, wrapping surgical gloves, lifts flap up to tuck it inside the glove cuff.

Dorothy Lincoln ties glove packages, which are now ready to go to the central supply department for autoclaving. Gloves are issued from and returned to central supply.

All glove envelopes are made in the laundry sewing room. Here Mrs. Dorothy Bernstein, of the sewing room staff, puts the finishing touch on an envelope.

Left: Dorothy Kelly (l.) and Nora McMahon put inner wrap on a surgical pack. Right: They add the outer wrap. Instead of tape being used to hold the two ends of the inner wrap together, a strip of gauze is pinned on at both ends of the folds.



Right: Packs are loaded directly onto a big canvas, hamper-type cart and sent to the central supply department where the autoclaving is done.

Herbert Knox (l.), assistant foreman, loads contaminated linen into an autoclave for sterilizing before washing. Watching the operation is Walter Smith, foreman. Double bags with a blue stripe indicate contaminated linen. Floor personnel usually take the additional precaution of labeling such linen as infected or contaminated.

On our floor
SEND THREE SUX-CERT TO O.R. 4 - THEY'RE STANDARD FROM NOW ON.
OH YES... LYOPHILIZED SUCCINYLCHOLINE CHLORIDE IN THAT HANDY INCERT® SINGLE-DOSE VIAL.
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6. Do not overload or overheat the tumbler.

PACKAGING

After drying, gloves are sent to the central glove room in another section of the laundry, for testing, powdering, and packaging for autoclaving.

The glove room is not a cubicle with bank-type partitions; it is a closed room, so that the glove powder does not drift out into the rest of the laundry but is fairly well confined to the room. Personnel in the glove room wear scrub gowns over their street clothes and also wear masks when they are using the powder — to protect their nose and throat passages from irritation.

From this room the gloves go to the central supply department for autoclaving.

PACK ASSEMBLY

When the laundry assumed the responsibility of assembling surgical and obstetrical packs, three years ago, operating-room personnel spent about one month training laundry personnel to fold linens and wrap packs. Since that initial training period, however, experienced laundry personnel have trained any new workers in these tasks.

Packs are loaded into big carts and sent to the central supply department for autoclaving, just as the gloves are. Actually, if the necessary equipment and space were provided in a hospital laundry, there is no reason why the autoclaving could not be done there as well.

Supplies are requisitioned by the floors from the central supply department.

Our main problem at present is a need for additional space, which will be provided in a building program scheduled to begin soon. A balcony to be added will give more space for the department's office. Rearrangement of some of the other areas will allow more space for pack assembly, which is now done in a small area at one end of the main laundry room.

What about a laundry for the small hospital? How big should a hospital be to make a laundry installation practical? Ordinarily, we would say it is not practical for a hospital under 100 beds to have its own laundry. However, because of the increase in incidence of staphylococcal infections, it may be dangerous for a hospital to use a commercial laundry.

Even if hospital personnel always autoclave contaminated linen before sending it out to the laundry, they may get back, not the linen they sent out, but linen from another institution which perhaps does not autoclave before laundering.

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AND IT'S STABLE, STERILE AND READY FOR INSTANT RE-CONSTITUTION IN BULK I.V. SOLUTIONS.
NO AMPULES, NO NEEDLES, NO SYRINGES. . . . JUST PUMP A LITTLE FLUID INTO THE VIAL, INVERT AND PUMP BACK INTO THE I.V. BOTTLE. WHAT A TIME-SAVER!
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Pharmaceutical Products Division of **BAXTER LABORATORIES, INC.**

(Continued from page 66)

VA Nursing Appointments

Esther Jencks—is now chief, nursing service, VA Hospital, White River Junction, Vt. Prior to transfer she held a similar position at the New Orleans VA Hospital.

Emma Landrum—is now chief, nursing service, Jackson, Miss., VA Hospital. Prior to transfer she was assistant chief, nursing service, Montgomery, Ala.

Amanda Lerch—is chief, nursing service, Mountain Home, Tenn., VA Hospital. Prior to transfer she held a similar position at the VA Hospital, White River Junction, Vt.

Betty Mueller—is assistant chief, nursing education, VA Hospital, Downey, Ill., where she was formerly an instructor.

Myrtle Olstad—has been named chief, nursing service, VA Hospital, New Orleans. She previously held a similar position at the Alexandria, La., VA Hospital.

Gloria Sorrentino—has been appointed assistant chief, nursing education, VA Hospital, Butler, Pa. Prior to transfer, she was an instructor at the Sunmount, N.Y., VA Hospital.

New Officers

Sample B. Forbus, director, Watts Hospital, Durham, N. C., recently was installed as president, North Carolina Hospital Association. New vice-president is **Edward R. Frye,** administrator, Good Samaritan Hospital, Charlotte. **J. Minetree Pyne**, administrator, Alamance County Hospital, Burlington, succeeds Mr. Forbus as secretary-treasurer.

* * *

John W. Rankin, director, Milwaukee County (Wis.) Institutions, recently was elected president, Tri-State Hospital Assembly.

Other new officers are: **George E. Cartmill Jr.,** director, Harper Hospital, Detroit, vice-president; **Sister Mary Reginald, R.S.M.,** Mercy Community Hospital, Manistee, Mich., secretary; and **Delbert L. Price,** administrator, Children's Memorial Hospital, Chicago, treasurer.

* * *

R. C. Scruggs, administrator, Crittenden Memorial Hospital, West Memphis, Ark., has taken over as president, Arkansas Hospital Association.

Other new officers are: **Nelson F. Evans,** administrator, University of Arkansas Medical Center, Little Rock, president-elect; **Rick Campbell,** Little Rock, executive secretary; **Robert A. Berryman,** administrator, Randolph County Memorial Hospital, Pocahontas, treasurer.

Deaths

Gordon Goree—administrator for the past eight years of the Shawnee (Okla.) City Hospital, died May 1.

Raymond W. McNealy, M.D.—69, president of the attending staff, Cook County Hospital, Chicago, since 1931, died July 29. He had been chief of staff and first superintendent, Chicago Wesley Memorial Hospital.

The ZIMMER MANUFACTURING COMPANY, Warsaw, Indiana announces an exclusive *Direct Selling Plan* for the United States

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LOOK FOR THE TRADEMARK Ⓩ

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Morris Kurtzon—83, founder and first president, Mount Sinai Hospital, Chicago, died July 24. Mr. Kurtzon was president of Mount Sinai for 26 years.

John Maxwell—purchasing agent, Waterbury (Conn.) Hospital for 25 years, died July 7.

Mrs. Isabelle C. O'Donnell — 56, former superintendent, Arnold Gregory Memorial Hospital, Albion, N.Y., died July 8. She was superintendent from 1929 to 1936, and for a brief period later.

Raymond G. Taylor, M.D. — 86, former superintendent, General Hospital, and retired head, Good Samaritan Hospital, both in Hollywood, Calif., died June 20.

Charles Wardrop — former director, Shriners' Hospital for Crippled Children, Salt Lake City, died July 9.

Harry Jennings Worthing, M.D.—70, director, Pilgrim State Hospital, West Brentwood, N.Y., for the past 21 years, died July 22.

Dr. Worthing is credited with introducing electric shock treatments into the United States.

Northwestern Confers 62 Administration Degrees

Sixty-two students received Master of Science degrees in hospital administration from Northwestern University in June.

Special award winners in the class included: James J. Herman, Chicago, Malcolm T. MacEachern award; Charles R. Sanders, Dallas, Tex., Mary H. McGaw award; Francis E. Lambert, Cleveland, O., and Kenneth G. Van Bree, Racine, Wis., Fred Geck award; and Clifford M. Lebo, Harrisburg, Pa., and Earl Raps, Chicago, American Surgical Trade Association awards.

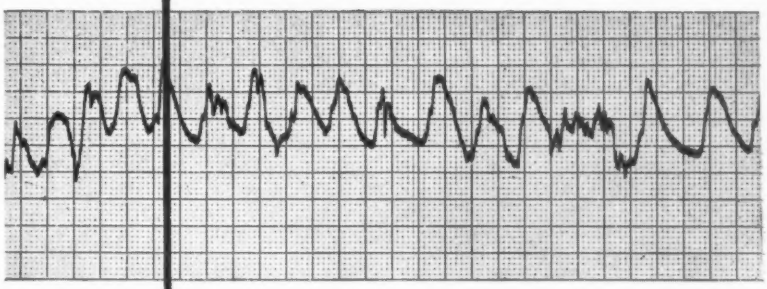
Appointments announced for degree recipients are these: John J. Brandel, administrator, Portsmouth (O.) Receiving Hospital; Robert B. Baylor, administrator, Lima (O.) State Hospital; John E. Bertone, assistant director, Southern Nevada Memorial Hospital, Las Vegas; John Beyer, assistant administrator, Presbyterian Hospital Center, Albuquerque, N. Mex.; Delos J. Bristor, administrative assistant, Longview State Hospital, Cincinnati, O.; John L. Byrne, administrator, Children's Medical Center, Tulsa, Okla.

James E. Champer, administrative assistant, Louis A. Weiss Memorial Hospital, Chicago; Merle H. Charney, administrative assistant, Jewish Hospital Medical Center, Cincinnati, O.; In Hae Chung, administrative assistant, Worcester (Mass.) City Hospital; Russell T. Clayton, assistant administrator, Baroness Erlanger Hospital, Chattanooga, Tenn.; Ivan H. Corner, Jr., administrative assistant, Doctors Hospital, Cleveland Heights, O.; Robert A. Cunningham, assistant administrator, Nassau General Hospital, Fernandina Beach, Fla.; Joseph M. DeFilippo, assistant administrator, Fitkin Memorial Hospital, Neptune, N.J.

Frieda E. Enss, assistant administrator, St. Louis Children's Hospital; John A. Erlman, personnel director, Mercy Hospital, Springfield, Mass.; William A. Gaunt, assistant administrator, Presbyterian Hospital, Denver; Abraham Gelperin, M.D., director of public health, Kansas City, Mo.;

(Continued on page 140)

Tragedy



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... the tragedy, for patient AND surgeon, that begins with ventricular fibrillation when adequate emergency equipment is not available.

A LEADING SURGEON RECENTLY PREDICTED:
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To stop ventricular fibrillation through the application, directly to the ventricles of the heart, automatically or manually timed and strength-controlled electrical shock. Complete with new 3-inch concave electrodes.

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For external application in cases of cardiac and circulatory arrest to re-establish, through automatic electric surges, properly paced ventricular rhythm—for hours or days, as may be required. Indicated in many emergencies.

A collection of reprints from medical journals on the subject of cardiac arrest and resuscitation, including a cardiographic record of fibrillation, cardiac arrest and resuscitation will be sent on request.

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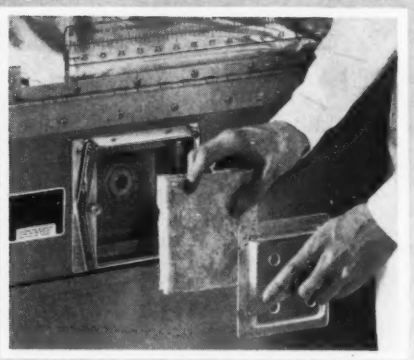

Pathogen-free nursery air: new MICRO-FILTER removes contaminants from nursery air.

Safe, economical control of oxygen: unique, oxygen-limiting "relief" valve restricts O_2 concentration to 40%, regardless of flow rate.

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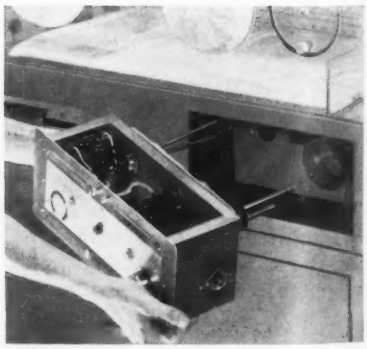

Removable power unit: compact, lightweight —is easily and quickly removed for cleaning or replacement of parts.

Easy to clean: newly designed conditioning chamber—a one-piece, smooth aluminum casting is quickly and easily cleaned.

THE **NEW ISOLETTE®** PROVIDES—

- True isolation
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- Precise control of environment
- Unique O_2-limiting valve
- Removable power unit
- Molded plastic entry ports

The new model C-77 Isolette infant incubator has been designed to provide many important new features while retaining all the precise atmospheric controls of the earlier model. In addition all ISOLETTE accessories—the VAPOJETTE®, ISOLETTE ROCKER, and weighing scale—fit the new C-77 ISOLETTE.

of the NEW *Isolette*®

infant incubator by *AIR-SHIELDS, INC.*

To provide every advantage for the new-born or premature infant . . .

THE NEWLY DESIGNED ISOLETTE infant incubator (Model C-77) retains and refines *all* the outstanding advantages of the earlier model, and provides many important new features as well:

True isolation—(1) by use of air from *outside* the hospital or, (2) by use of the new MICRO-FILTER which removes 99.50% of contaminants as small as 0.5 micron (average *staphylococcus* is 0.8 micron*) from *nursery* air. Thus, a constant supply of pathogen-free air from outside the hospital, or micro-filtered nursery air safeguards the infant from air-borne or droplet infection.

Easily cleaned—one-piece, smooth aluminum conditioning chamber, with rounded inside corners—no inaccessible areas to become contaminated with bacteria.

Relative humidity control—simple to operate and easy to clean—maintains stable R.H. as high as 85% to 100%, independent of temperature.

Temperature control within $\pm 1°F$.

Efficient cooling system ensures safe incubator temperatures even when nursery temperature exceeds 95°F.

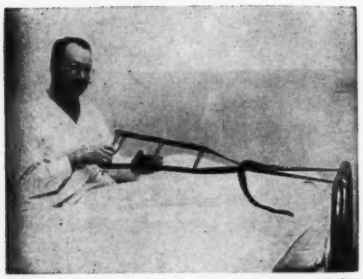
Unique O_2-limiting valve—restricts concentration to 40% even when high flows are used by unique "relief" valve which bleeds excess oxygen outside the ISOLETTE. Low or high concentrations can also be maintained.

Removable power unit—compact, lightweight power unit containing heating element, operating and safety thermostats, and air-circulating blower fits snugly into conditioning chamber. The new power unit is easily removed for replacement of parts.

For additional information about the *new, model C-77* ISOLETTE, phone us collect (OSborne 5-5200) or write AIR-SHIELDS, INC., Hatboro, Pa.

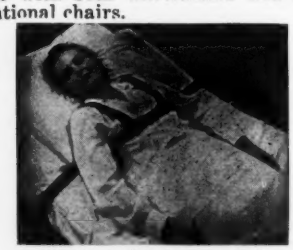
*Zinsser, H.: Bacteriology, ed. 11, New York, D. Appleton-Century Co., Inc. 1957, p. 244.

For Patient Protection



The New Posey "Patient Aid"
The new Posey "Patient Aid" is another rehabilitation product which encourages self-exercise and is a positive aid to the geriatric. The patient can raise himself without calling for the nurse.
Catalog #B-654 (For open end beds) $5.95 each. Catalog #B-654A (For beds with solid foot ends) $5.95 each.

Posey Patient Support
Standard Model: PP-753. $6.75.
Adjustable Model: PP-154, $7.50.
Gets your patient out of bed . . . useable with both wheelchairs and conventional chairs.



McDonald Restraint
Standard Model: P-4147, $6.15. Extra-heavy model: P-353. Riveted construction with keylock buckles, $19.80 each. Keeps patient in bed.

SEND YOUR ORDER TODAY
And Write for Illustrated Literature About Other Posey Hospital Equipment

J. T. POSEY COMPANY
2727 E. Foothill Blvd.
Dept. HT
Pasadena, California

PERSONALS

(Continued from page 137)

Richard M. Heath, administrator, Orient (O.) State Institution; James J. Herman, assistant administrator, St. Luke's division, Presbyterian-St. Luke's Hospital, Chicago; Frederick L. Hinchee, administrator, Shawnee (Okla.) Municipal Hospital; Richard E. Holladay, administrative assistant, Baptist Hospital, Pensacola, Fla.

Louis J. Jansa, administrative assistant, Herrick Memorial Hospital, Berkeley, Calif.; Theodore F. Kaap, Jr., administrator, Mennonite Hospital, Bloomington, Ill.; Robert W. Keller, administrator, Kiowa County Memorial Hospital, Greensburg, Kans.; William J. Kramer, executive secretary, San Francisco Hospital Conference; Francis E. Lambert, administrative assistant, Cleveland (O.) State Hospital; Luther Landon, II, administrative assistant, Decatur (Ill.) and Macon County Hospital; Glen H. Lauth, administrative assistant, Lutheran Hospital, Moline, Ill.

Clifford M. Lebo, assistant superintendent, Harrisburg (Pa.) Hospital; John P. Leicht, administrator, Henry Schmitz Medical Foundation, Chicago; Donald C. Leine, administrative assistant, Fairview Park Hospital, Cleveland, O.; William D. Locke, administrative assistant, Lankenau Hospital, Philadelphia; Jim MacLuker, administrative assistant, The Methodist Hospital, Lubbock, Tex.

Clay M. McCluskey, North Carolina Baptist Hospital, Winston-Salem; John K. Miles, Jr., administrative assistant, Vanderbilt University Hospital, Nashville, Tenn.; Walter H. Miles, II, administrative assistant, Shannon West Texas Memorial Hospital, San Angelo; Don A. Myers, assistant administrator, Maury County Hospital, Columbia, Tenn.

John F. Norwood, business office, St. Luke's division, Presbyterian-St. Luke's Hospital, Chicago; Hansel B. O'Quinn, assistant administrator, Baptist Hospital, Alexandria, La.; Hugh R. Owens, assistant administrator, Tacoma (Wash.) General Hospital; Catherine G. Papaeconomou Apostolopoulou, administrator, General Hospital Evangelistia, Tripolis, Greece; Capt. John E. Pasch, USAF Hospital, Wiesbaden, Germany; Lionel G. Price, administrative assistant, Methodist Hospital, Indianapolis.

Earl Raps, administrative assistant, Mount Sinai Hospital, Chicago; Thomas B. Reed, administrator, Foley (Ala.) Hospital; Robert D. Reeves, administrative assistant, University Hospital, Jackson, Miss.; Poerner E. Riehl, administrator, Polly Ryon Memorial Hospital, Richmond, Tex.; Charles R. Sanders, administrative assistant, Dallas County (Tex.) Hospital District; Maurice B. Shaw, administrator, Bataan Memorial Hospital, Albuquerque, N. Mex.; Vernon C. Showalter, assistant administrator, Bethany Hospital, Chicago; Thomas J. Streit, administrative assistant, DuPage County Memorial Hospital, Elmhurst, Ill.

John O. Tucker, night administrator, University Hospital and Hillman Clinic, Birmingham, Ala.; Kenneth G. Van Bree, administrative assistant, St. Luke's Hospital, Racine, Wis.; Leonard E. Watson, assistant administrator, Highland General Hospital, Pampa, Tex.; Windsor D. Wilder, administrative assistant, Hollywood Presbyterian Hospital, Los Angeles; George H. Yeckel, administrative assistant, St. Luke's Hospital, Kansas City, Mo.; John L. Yoder, administrative assistant, Fitkin Memorial Hospital, Neptune, N.J.

Announce Residencies for U. of Chicago Graduates

The following students have completed the academic portion of their work in the University of Chicago's Graduate Program in Hospital Administration. Their appointments to administrative residencies are: David L. Allen to G. Otis Whitecotton, M.D., medical director, Highland-Alameda County Hospital, Oakland, Calif.; William L. Boyd to George K. Hendrix, administrator, Memorial Hospital, Springfield, Ill.

Thomas J. Broderick to Donald C. Carner, administrator, Seaside Memorial Hospital, Long Beach, Calif.; Jerry L. Buckingham to Albert H. Scheidt, administrator, Dallas (Tex.) City-County Hospital; Gerald B. Cole to Edmund J. Shea, administrator, Indiana University Medical Center, Indianapolis; Thomas E. Coull to Frank S. Groner, administrator, Baptist Memorial Hospital, Memphis, Tenn.; Dean E. Leiser to Alexander Harmon, superintendent, City Hospital, Cleveland, O.

Lee Pridgen, Jr., to military service; Jack C. Robinette to Peter A. Volpe, M.D., administrator, Ohio State University Hospital, Columbus; James R. Shawver to Erwin J. Remboldt, administrator, White Memorial Hospital, Los Angeles; Alfred J. Sparkes, Jr., to J. Milo Anderson, administrator, Strong Memorial Hospital, Rochester, N.Y.; Lauro Vivaldo-Fernandez, M.D., to Everett Johnson, administrator, Methodist Hospital, Gary, Ind.

TRADE TOPICS . . .

Sales Executive Named By Walker Laboratories

Joseph F. Pendrak, formerly field sales manager, has been named assistant general sales manager, Walker Laboratories, in line with the company's sales expansion program.

Mead Johnson Reveals Two Appointments

James W. McNeil, M.D., has been promoted to medical director, nutritional and pharmaceutical division, Mead Johnson & Co. Formerly associate medical director of the division, he succeeds M. J. Sweeney, M.D.

W. Alan Wright, M.D., has been named medical director of Mead Johnson International, the company's foreign operations division. He was formerly medical director, Charles Pfizer & Co., Inc.

Three New Appointments Told At Oakite Products

Clarence Bremer, Ph.D., formerly director of research, has been appointed technical director of Oakite Products. Dr. Bremer has been with the company since 1942, and a member of the board of directors since 1956.

J. Justin Basch has been appointed to the new position of marketing vice-president. Formerly vice-president for research and product development, Mr. Basch will now also be responsible for sales, engineering, advertising, and marketing research.

William A. Baltzell, formerly assistant sales manager, has been appointed industrial sales manager for Oakite.

President Named by Armour Pharmaceutical

Robert A. Hardt has been appointed to the newly created post of president of Armour Pharmaceutical, and also named vice-president of Armour & Co.

Previously executive vice-president of Hoffmann-LaRoche, Inc., Mr. Hardt has also been vice-president of E. R. Squibb & Sons. He is a past president of the American Pharmaceutical Manufacturers Association and of the National Pharmaceutical Council.

Lehn & Fink Products Names Field Sales Manager

Charles F. Manz has been appointed field sales manager, professional division, Lehn & Fink Products Corp., with headquarters at the company's executive offices in New York City.

Mr. Manz is being transferred from the Lehn & Fink, Inc. division of the company, where he was Chicago regional sales manager.

Harris Willits (l.), Hospital Industries' Association, presents Thomas A. Crowley, assistant sales manager, hospital division, Johnson & Johnson, with a plaque for the best multiple booth display at the recent Middle Atlantic Hospital Assembly. Johnson & Johnson's exhibit described the "Patient-Ready Sterile Story."

Audio Digest Subscriptions Sponsored by Schering

Schering Corp. is sponsoring 200 one-year subscriptions for teaching hospitals to Audio Digest, a service consisting of tape recordings of medical articles, clinical reviews, and lectures.

Each tape also will include a report on research developments at Schering.

William G. O'Brien has been appointed supervisor, Audio-Visual Section, and will be in charge

(Continued on next page)

Several groups have recently toured the St. Louis plant of Shampaine Co. as part of the company's educational program in product knowledge for hospital personnel. In the picture at left, Gilbert Shampaine (r.), sales co-ordinator, points out the assembly process of an operating table to hospital administration students from Washington University, St. Louis, during Shampaine's seventh annual seminar in hospital equipment. At right, Mr. Shampaine (l.) explains spot welding process to members of the Catholic Purchasing Agents Association. Other meetings have been held for hospital administration students from St. Louis University and for Catholic food service administrators from 28 states and 7 Canadian provinces.

of the Audio Digest program, films, and exhibits for the company.

Air Filtering Equipment to Be Tested by Mobile Lab

A mobile laboratory devised to test air filtering equipment will soon begin a nation-wide tour.

Outfitted by Trion, Inc., it will contain air testing equipment which duplicates that used by the National Bureau of Standards. Air filtering demonstrations will be given to architects, air conditioning engineers, contractors, and engineering students.

$50,000 Smallpox Lab To Be Sent To Pakistan

Arthur S. LaPine and Co. is assembling a complete medical laboratory for the preparation of calf lymph dried smallpox vaccine to be shipped to Dacca, capital of East Pakistan.

The laboratory will be set up under the auspices of the International Co-operation Administration, to innoculate fifty million Pakistanis for prevention of smallpox and cholera.

Gift of Microscope Slides To Aid Medical Research

A supply of 36,000 pre-cleaned microscope slides has been presented by John Coleman, Glasco Products Co., to Francis Cardinal Spellman in the name of the late Sister Marie Suzanne for continuance of her work.

Sister Suzanne's medical research resulted in a successful anti-leprosy vaccine which is available at no charge to victims of leprosy throughout the world.

DOROTHEA BOWLBY ASSOCIATES

A specialized employment service for medical and hospital personnel

8 S. Michigan Ave., Suite 1420
Chicago 3
ANdover 3-5293

Dorothea Bowlby, Director

Confidential listings (men and women) for administrators, personnel directors, business managers, dietitians, physicians, directors of nurses, therapists, pharmacists, medical record librarians, anesthetists, public relations directors, housekeepers, bacteriologists, biochemists, anesthetists, medical technologists, x-ray technicians, food service managers.

All inquiries are strictly confidential.

Edward J. Marlotte (l.) presents the annual Fred Geck Awards, sponsored by Surgical Products division, American Cyanamid Co., to Northwestern University, hospital administration students Francis E. Lambert (center) and Kenneth Van Bree for papers written for Master's degree requirements in the program of hospital administration.

News Briefs

Doho Chemical Corp. — has acquired Ophthalmos, Inc. **Robert R. Feinstein** will remain as director, pharmacologic research for the care and preservation of vision.

* * *

Dayton Rubber Co.—recently dedicated its new Freedlander Research and Development Laboratories at Hawthorne, Calif.

* * *

Fred Moynahan — has been appointed district sales manager for the mid-eastern hospital district, Bauer & Black, with headquarters in Philadelphia. Mr. Moynahan was formerly in charge of training Bauer & Black hospital specialists in the selling of sutures.

* * *

Du Pont Photo Products Department—E. I. du Pont de Nemours & Co., has announced the following sales division appointments: Harlan L. Graham, director of sales; Frederick B. Astley, assistant director of sales; John L. Morgan, manager of sales service; A. Crawford Hubbard, manager of x-ray product sales; and David P. Hurley, sales supervisor, trade and industrial products, New York district.

* * *

Seamless Rubber Co. — recently moved its Chicago headquarters to 2321 W. Pershing Road.

* * *

Robert M. Chiaviello—has been appointed general manager, Emergency Kit Corp. He had been a consultant in the medical and surgical field.

* * *

Milton H. Freeland—former manager, Indianapolis sales district, Abbott Laboratories, has been appointed assistant manager, drug trade division, at the company's headquarters in North Chicago, Ill. Succeeding Mr. Freeland at the Indianapolis post is Robert D. Hickman, formerly an Abbott salesman in Indianapolis.

* * *

President Eisenhower's appointment of **Ernest H. Volwiler, Ph.D.**, chairman of Abbott's board of directors, to the board of the National Science Foundation has been confirmed by the U.S. Senate.

(Continued on page 144)

Rollpruf® Surgical Gloves by PIONEER

RP-158 Tissue-thin Flat Banded White Latex.

RP-169R Brown Latex with Non-Slip *Fingers and Palms.*

RP-168 Tissue-thin Flat Banded Brown Latex.

75-LW Green Neoprene for persons allergic to rubber.

...Flat-Banded Cuff Won't Roll Down During Surgery

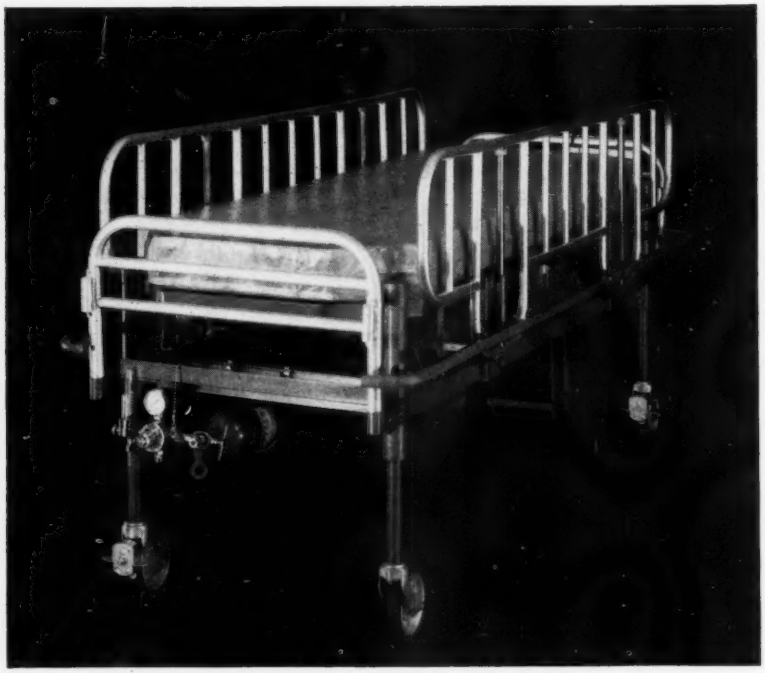
...Pair for Pair Uniformity Within 1/1000th inch

...Quality-Made and Individually Inspected

the PIONEER Rubber Company
328 Tiffin Road, Willard, Ohio

Pioneers In Surgical Hand Protection for over 35 Years

Helping fight disease with atomic energy



Hill-Rom Hilow Recovery Bed to be used in clinic at International Conference in Switzerland

● Sponsored by the United Nations, the second International Conference on Peaceful Uses of Atomic Energy is to be held in Geneva in September. Patients from central Europe, brought in by doctors from that area, will be examined. In the clinic on Radioisotope Therapy, the new Hill-Rom Hilow Recovery Bed will be used. Doctors who have been using this method of examination have been able to detect tumors in various organs of the body, and those in charge of the clinic are hopeful that eventually it will be possible to isolate a tumor in any area of the body.

Hill-Rom is proud that this latest addition to our line of Hilow Beds has been selected for this important assignment which holds so much promise and hope for patients throughout the world.

The No. 45-6 Hilow Recovery Bed—Labor Bed—Special Therapy Bed has been designed to answer special needs in equipment for use in Recovery Rooms, Labor Rooms and Treatment Rooms. This 8-page bulletin sent on request.

HILL-ROM COMPANY, INC., BATESVILLE, INDIANA

TRADE TOPICS

(Continued from page 142)

Dr. Volwiler recently was one of 100 Midwesterners cited by Indiana Technical College for contributions to science, engineering, and industry.

* * *

Jack T. Edmondson — has announced his availability as manufacturers' representative on the West Coast. He was sales representative and western division sales manager for Ethicon, Inc., for 21 years.

* * *

James W. Nelson—is head of a new firm, Crescent Biological Laboratories Corp., with headquarters in Brooklyn, N.Y. The company will specialize in products for clinical and diagnostic laboratories. Mr. Nelson was formerly marketing director, Schieffelin & Co.

* * *

American Sterilizer Co.—has announced promotion of Arthur B. Weindorf to purchasing agent, and Henry Skovron to field service manager. Mr. Weindorf had been assistant purchasing agent for Amsco. Mr. Skovron formerly was associated with the Detroit and Chicago offices of the firm.

* * *

Coleman Instruments, Inc.—has appointed Robert J. Roth as director, chemical laboratory, and Joseph C. Elkins as southwestern sales representative, with offices in Houston, Tex.

* * *

Paul D. Scheele—has been appointed manager of the Kansas City division, American Hospital Supply Corp. Mr. Scheele, formerly assistant to the vice-president in charge of sales, has been with the firm since 1947.

* * *

Selby D. Hussey — has been appointed sales manager, John Bunn Corp. He was formerly a sales representative, Milwaukee area, for Physicians and Hospital Supply Co.

BUYER'S GUIDE Information Service

BUYER'S GUIDE

500. Gas monitor
501. Radiation warning signs
502. Hand dryer
503. Air filter
504. Stoppering device
505. Emergency light
506. Liquid nitrogen generator
507. Oxidase discs
508. Gas connector
509. Freezer containers
510. Rehabaphone
511. Sedentary workers' chair
512. Utility cart rack
513. Coffee urn battery
514. Colostomy case
515. Dish dispenser
516. Disposable slipper
517. Cardiology set
518. Diagnostic audiometer
519. Surgical dressing
520. Staple instruments
521. Laboratory cleaner
522. Automatic film processor
523. Biopsy instrument
524. Folding wheel chair
525. Photometer
526. Heart monitor
527. China place setting
528. Portable floor lamp
529. Hemophotometer
530. Fluorescent lamp guard
531. Nurse call system
532. Chart file system
533. Wall covering
534. Bed power-lift

FILMS, NEW LITERATURE

540. Safety codes
541. Laboratory scales
542. Monomers-polymers
543. Iodophor germicide
544. Acoustical tile
545. Buccal Varidase
546. Prostate surgery
547. Antimicrobial agents
548. Binary scaler
549. Psychiatric nursing
550. Centrifugal fans
551. Surgical procedures
552. Electron microscope
553. Paper products

AHA CONVENTION

C560. Intermittent vacuum regulator
C561. Mattress and bedding disinfector
C562. Rubber and vinyl flooring
C563. Portable cassette holder
C564. Motorized bed

C-565. Antibiotic
C-566. Converta-bed
C-567. Detergent
C-568. Plastic suture pack
C-569. Disposable coil kidney
C-570. Patient valette
C-571. Disposable I. V. set
C-572. Patient card system
C-573. Skin lotion
C-574. Disposable syringe-needle
C-575. Disposable obstetrical drapes
C-576. Thoracic thermotic pump
C-577. Ultrasonic cleaner
C-578. Dusting powder
C-579. Bedside control center
C-580. Folding wheel chair
C-581. Bedside cabinet
C-582. Stencil pad
C-583. CircOlectric bed

USE THIS CARD

Just circle the number on the postpaid reply card for information you would like.

C-584. Surgical glove wrap
C-585. Disposable plastic catheter
C-586. Pocket size doctors' bag
C-587. Nurse-patient intercom
C-588. Sterile dressings
C-589. Bed and table
C-590. Heating, cooling pad
C-591. Ophthalmic drops
C-592. Disposable surgical gloves
C-593. Twin surgical lights
C-594. Safety side rails

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First Class Permit No. 34341, Chicago, Illinois

HOSPITAL Topics
30 West Washington Street
Chicago 2, Ill.

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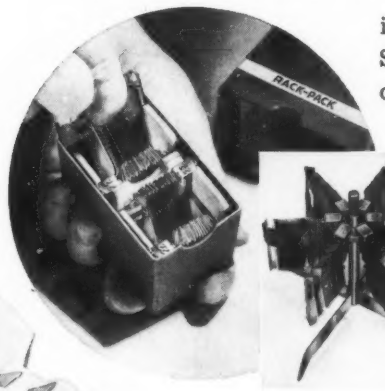
BUSINESS REPLY CARD
First Class Permit No. 34341, Chicago, Illinois

HOSPITAL Topics
30 West Washington Street
Chicago 2, Ill.

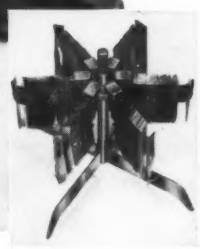
An EDGE on them all

Cutting efficiency and maximum blade performance has always been the surgeon's first consideration when choosing a surgical blade. BARD-PARKER offers you a blade made with the same consideration in mind . . . a blade of *carbon steel* of course . . . so superior for *fine cutting edges.*

B-P RIB-BACK Blades are now available . . .



in the Puncture Proof Sterile Blade package that can be autoclaved.



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(1) Hagedorn, A. B.: Proc. Staff Meet. Mayo Clin. 32:705 (Dec. 11) 1957.
(2) Best, W. R.; Louis, J., and Limarzi, L. R.: M. Clin. North America (Jan.) 1958, p. 3.

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